Substance Abuse Treatment For Persons With Co-Occurring Disorders

Inservice Training

Based on
A Treatment
Improvement
Protocol

TIP 42

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

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1 Choke Cherry Road
Rockville, MD 20857

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Disclaimer

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TRAINER'S ORIENTATION

Introduction

The *Substance Abuse Treatment for Persons with Co-Occurring Disorders Inservice Training* manual is based on Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders*. Provided by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment, TIPs are best-practice guidelines for the treatment of substance use disorders.

The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs. CSAT works with the State Alcohol and Drug Abuse Directors to generate topics based on the field's current need for information and guidance.

After selecting a topic, CSAT invites staff from Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources for developing the TIP content. These recommendations are communicated to a Consensus Panel composed of experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

While each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations in the TIP are attributed to either Panelists' clinical experience or the literature.

To facilitate the transfer of science to service, the *Substance Abuse Treatment for Persons with Co-Occurring Disorders Inservice Training* manual provides a structure for introducing addiction counselors and other practitioners to the state-of-the-art information on the rapidly advancing field of co-occurring substance use and mental disorders provided in TIP 42.

Training Goals and Objectives

Overall goal: To transfer the evidence-based knowledge presented in TIP 42 to frontline clinicians, thereby initiating application of the state-of-the-art information and approaches to the treatment of persons with co-occurring substance use and mental disorders.

Objectives: Participants who complete the Inservice Training will:

- Familiarize themselves with the TIP 42 document
- Explore the range of information available in the TIP
- Understand key concepts presented in the TIP
- Apply TIP 42 information to clinical situations

Audience

The *Substance Abuse Treatment for Persons with Co-Occurring Disorders Inservice Training* manual provides materials for training substance abuse treatment clinicians and other treatment program professionals. It is designed for delivery by clinical supervisors with their staff and can give clinical supervisors insight into the strengths and challenges of programs and staff regarding approaches to treatment of co-occurring disorders. It can help the clinical supervisor identify areas where more in-depth training is needed for their staff and where programs need enhancement or modifications. A training environment that includes a mix of treatment professionals with various degrees of experience facilitates peer-to-peer teaching and learning.

Ideally, the training group should be large enough to split into at least four small groups of three members each. The training materials can be adjusted for smaller or larger groups as needed. A limit of 35 training participants is suggested to facilitate authentic and open discussion, interaction, exploration of challenges and brainstorming solutions.

To meet the objectives of becoming familiar with the TIP 42 document and exploring the range of information in the TIP, ***each training participant must have a copy of TIP 42.***

TIP 42 is the primary participant text for the training. The Inservice Training manual is *designed for use with TIP 42*. It is not intended as a replacement or substitute for reading the entire TIP 42 document.

TIP 42 can be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI) at http://ncadi.samhsa.gov/ or by calling their toll-free number: (800) 729-6686
TDD: (800) 487-4889
Español: (877) 767-8432

The complete TIP 42 can be accessed via the Internet at the URL: www.kap.samhsa.gov.

Trainers

A primary training task is to motivate participants to use the TIP 42 document and to help develop their comfort level in doing so. Trainers will need to demonstrate that this training is not meant to replicate the TIP information but to explore and use the document itself. Trainers, therefore, should familiarize themselves with the document so their modeling will be effective.

From the very first training experience participants are referred to pages in the TIP. They are intentionally required to flip back and forth through the chapters and appendices, and referred to figures and graphs in the document *rather than being shown slides of the TIP material*. This helps participants appreciate the variety and usefulness of the material contained in the TIP. It also establishes that the books are required for each training session.

The more participants handle and use the TIP during the training, the greater the chances are that they will refer to it outside of the training time.

Customizing the modules: There is more information in most modules than can be delivered in the allotted 45 minutes. This gives the trainer an opportunity to adjust delivery to the participants' needs and preferences. Groups may wish to know more about certain topics relevant to their practice, and less about others.

To assist in this effort, the module information is organized using various types of bullets and degrees of indentation to provide cues to the trainer regarding content that is of primary, secondary and tertiary importance. An example layout includes:

- Primary importance
  - Secondary importance
    - Tertiary importance

Trainer Notes within the script offer alternatives to follow and quick, easy to access instructions. They follow the same outline to emphasize the degree of the note's importance for training the material. Trainer Notes look like this:

Trainer Note:

- Trainer Notes look like this.

Discussion questions and activities: These are intended to help participants connect the material to their practice and to encourage higher order learning. In most cases, the trainer is urged to customize the more didactic review of information to allow full time for discussion and activities.

Activities for Higher Order Learning

The concept of higher order learning was introduced by Benjamin Bloom and a group of educational psychologists in the late 1950s. These psychologists developed a framework known as Bloom's Taxonomy—a classification of six (6) levels of intellectual behavior that require students to think and learn at increasingly higher levels.

The taxonomy places acquisition of basic knowledge at the lowest level of learning, with understanding, application, analysis, synthesis and evaluation of information at progressively higher levels (see Figure 1). All levels of learning are necessary; however, instructional methods that allow students to demonstrate increasing mastery of the material—beyond acquisition of basic knowledge—are required to achieve higher ordered learning.

Figure 1. Bloom's Taxonomy

Source: Bloom et al, 1956.

Adult students bring more life and work experience to the learning environment than younger students. For this reason, attention to instructional approaches that constitute best practice methods (or effective teaching and learning strategies) for adults is as important as the evidenced based clinical practices presented in this TIP.

Using adult learning best practice methods allows adult students to think and learn at increasingly higher levels because they are able to integrate the new material more effectively with their past experience. In addition, instructional methods that take into account the variety of students' cultural experiences and diverse learning styles have proven to be most effective in creating an optimal learning environment for adult students.

Some of the activities for higher order learning used in this training manual are:

- ***Direct instructional methods*** correlate to the Knowledge and/or Understanding levels of Bloom's Taxonomy.
  - ***Mini-lectures***
    An efficient way of providing information in a short period of time, these are 10-15 minutes in duration and mixed with group discussion and visual aids.
  - ***TIP ZIP Tests***
    Short quizzes that focus attention on key information and create curiosity regarding the content matter. These structured overviews of the module's content help the student organize and arrange the concepts to make them meaningful.
  - ***Didactic questions***
    Guided inquiry allows the adult learner to analyze the information for applicability, provides interaction, and allows learners to participate in customizing the presentation. It also helps the trainer understand what participants are thinking and their level of comprehension.
- ***Indirect instructional methods*** correlate to the Application and Analysis levels of Bloom's Taxonomy.
  - ***Case studies***
    Assigned scenarios based on real-life situations allow adult learners to observe, analyze, conclude, summarize and make recommendations.
  - ***Discussion***
    Encourages learners to think more deeply about a topic through discussion in dyads or small groups with other learners.
- ***Interactive instructional methods*** correlate to the Application, Analysis and Synthesis levels of Bloom's Taxonomy.
  - ***Role play***
    Allows students to gain a deeper understanding about their current treatment practices, attitudes, and beliefs and how those affect their behaviors in various work environments. Participants take on a different role than they might otherwise play in their daily life in order to illustrate or apply a learned theory. The audience sees the theory acted out—including the players' mistakes and creative problem solving strategies—as players seek to apply the theory in a new situation.
  - ***Report outs or peer teaching***
    Learners practice putting the new information in their own words and explaining the material to their peers. This tests the students' comprehension of the material at a deeper level and allows the trainer to see what is understood and what is misunderstood, which the trainer then has an opportunity to correct.
  - ***Jigsaw***
    An example of a peer teaching method in which students receive a portion of the information to be taught and then meet in "expert groups" to discuss the information and brainstorm ways to present it to their peers. Expert students then return to their home groups to teach the information to their peers; they learn other information from members of their home group who have become experts on a different topic.

- Experiential instructional methods correlate to the Evaluation level of Bloom's Taxonomy.
  - ***Behavioral rehearsal***
    Students are given an opportunity to practice new behaviors and skills, and receive feedback about their performance.

Needless to say, learning is not a linear process. The higher levels of learning represented in Bloom's Taxonomy incorporate elements from each of the previous levels.

The most important aspect of the taxonomy for trainers working with adult learners is to use instructional methods that provide opportunities for higher order learning. This curriculum is designed to provide these types of opportunities by offering several training options or activities in each module.

Adult Learning Principles to Remember:

- Adults need to integrate new concepts with what they already know if they are to retain and use the new information.
- Information that conflicts with what is already believed to be true forces a re-evaluation of the old way of thinking and is integrated more slowly.
- Adults benefit from dialogue with respected peers.
- An effective and productive training facilitator orchestrates the learning process for adults rather than advocating for a particular position or solution to a problem.

Using the Manual

This manual is intended for use as an in-service training, delivered over a period of time, with one module presented per training session.

Each module corresponds to the chapter of the same number in TIP 42. The content material of some chapters is covered in one 45-minute module. Other chapters require two or three 45-minute modules to adequately cover the content.

Module Overview

Each 45-minute module begins with introductory notes about the training delivery of that particular module, including:

- Objectives for learning
- Materials Needed for training
- Module Design overview
- Seating arrangement for participants
- Suggested Timetable for delivery of the module
- Complete script for delivery of the module; script is used by the trainer and guides participants through corresponding sections of the TIP.
- Specific trainer notes within the script
- Handouts
- PowerPoint slides

Some modules include training options for advanced participants or administrators. These may used at the trainer's discretion depending on the needs of the training audience.

Presentation Instructions

Each module is presented in a two column format. The left column contains icons that offer the trainer visual cues. The right column contains the complete training script used by the trainer.

Specific Trainer Notes are contained within the script and are designed to provide quick cues and/or reminders to the trainer about:

- General purpose of a particular section of the module
- Arrangements for training activities (e.g., specific instructions, time allocations, seating arrangements, and questions to ask participants during the activity)
- When to probe discussion responses to facilitate participants' connection with the material or to emphasize the intention of the training material
- Directions and discussions to include in the Wrap up Sections

Handouts

Trainers refer participants most often to TIP 42 in place of handouts, but sometimes handouts are used for training activities and distributed separately. Trainers will be alerted to training activities requiring handouts in the Materials Needed section of the modules introductory notes. The handouts are located in the Handout Section at the end of each module. Trainers will need to make copies of the handouts for all participants before each session.

Materials Needed for Each Module

- Copy of TIP 42 for each participant
- Overhead projector or laptop computer and LCD projector for slides
- PowerPoint slide presentation
- Handouts as needed for specific modules
- Highlighters or markers and Post-It notes for participants to mark their TIP 42 text while in session
- Kitchen timer

Also suggested:

- Notepad and markers
- Masking tape

Icons and Other Graphics

The following icons are used in the training manual:

Icon	Indicates
X minutes	The approximate time allotted for the section.
	Trainer Note: offers alternatives to follow and quick, easy to access instructions for the trainer.
	The trainer introduces an individual learning exercise.
	The trainer uses newsprint.
	The trainer introduces a small group exercise.
	The trainer introduces a two-person exercise.
OH #X-X	The trainer uses the overhead transparency (or PowerPoint slide) indicated.
	Indicates a cultural consideration highlighted in the training text.
	Indicates motivational interviewing highlighted in the training text.
	Indicates stages of change highlighted in the training text.
	The trainer refers to a TIP document.

Timetable for TIP 42 Training		
Module 1	Introduction to TIP 42	45 minutes
Module 2	Definitions, Terms, and Classification Systems for Co-Occurring Disorders	45 minutes
Module 3A	Keys to Successful Programming: Guiding Principles and Core Components	45 minutes
Module 3B	Keys to Successful Programming: Improving Substance Abuse Treatment Systems and Programs, and Workforce Development and Staff Support	45 minutes
Module 4A	Assessment: Screening, Step 1 and Step 2	45 minutes
Module 4B	Assessment: Step 3-Step 7	45 minutes
Module 4C	Assessment: Step 8-Step 12	45 minutes
Module 5A	Strategies for Working with Clients with Co-Occurring Disorders: Guidelines for a Successful Therapeutic Relationship	45 minutes
Module 5B	Strategies for Working with Clients with Co-Occurring Disorders: Techniques for Working with Clients with COD	45 minutes
Module 6A	Traditional Settings and Models: Essential Programming for Clients with COD	45 minutes
Module 6B	Traditional Settings and Models: Outpatient Substance Abuse Treatment Programs for Clients with COD	45 minutes
Module 6C	Traditional Settings and Models: Residential Substance Abuse Treatment Programs for Clients with COD	45 minutes
Module 7A	Special Settings and Specific Populations: Acute Care and Other Medical Settings, and Dual Recovery Mutual Self-Help Programs	45 minutes
Module 7B	Special Settings and Specific Populations: Specific Populations	45 minutes
Module 8A	A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues: Suicidality, Nicotine Dependence, and Personality Disorders	45 minutes
Module 8B	A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues: Mood Disorders, Anxiety Disorders, Schizophrenia, and Other Psychotic Disorders	45 minutes
Module 8C	A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues: AD/HD, PTSD, Eating Disorders, and Pathological Gambling	45 minutes
Module 9	Substance-Induced Disorders	45 minutes
TOTAL TIME		**13.5 hours**

MODULE 1: Introduction

Objectives

- Define co-occurring disorders
- Explore TIP 42 and how it is organized
- Review evolution of the co-occurring disorders (COD) field and its relevance to participants' practice
- Discuss the important developments that led to this TIP

Materials Needed

- Copy of TIP 42 for each participant
- Overhead projector or laptop computer and LCD projector for slides
- Slides #1.1-1.15
- Markers and Post-It Notes for participants to use on their TIP texts

Module Design

The primary function of the training and of this module is to motivate participants to use the TIP document and increase their level of comfort in doing so. From the very start of the training, participants are referred to pages in the document rather than being shown slides of the same material. The more the participants handle and use the TIP during the training, the greater the chances they will refer to it outside of the training.

Suggested Timetable for Module 1

Introduction ■ Trainers and Participants: Introductions—*5 minutes* ■ Introduction to TIP Training—*1 minute* ■ In This Module—*1 minute* ■ TIP Exercise—*5 minutes* ■ What Does the Term Co-Occurring Disorder Mean?—*3 minutes* ■ Discussion—*5 minutes*	20 minutes
The Evolving field of Co-Occurring Disorders ■ History and Implications of COD for Treatment Outcomes ■ Why a New TIP on Co-Occurring Disorders (COD)? ■ Availability of Prevalence and Other Data on COD ■ Treatment Innovation for Other Populations with COD ■ Changes in Treatment Delivery ■ Advances in Treatment ■ Some Recent Developments	20 minutes
Wrap up	5 minutes
TOTAL	**45 minutes**

20 minutes

OH #1-1

Introduction

Trainers and Participants—Introductions

Trainer Note:

- Because time dictates only 45 minutes for each session, introductions during this session will need to be very brief. Suggested steps and considerations for introducing the training, trainers, and participant introductions are included below.

- Welcome participants.
- Sponsors introduce training and trainers and establish credibility of both.
- Trainers then introduce their role; describe process for training, schedules, expectations and group norms.
- Participants then briefly introduce themselves if not known to each other.
- Distribute a copy of TIP 42 to all participants.

Trainer Note

- ***Introduction of training and trainers:*** Someone in a position of authority should introduce the training briefly giving the rationale, expectations, and introduce the trainer(s).
  - If the trainer is unknown to the participants, he or she will need to provide enough information in the introduction to establish his or her credibility with the participants.
  - Trainers describe process for training, schedules, expectations and group norms.

- ***Group norms:*** The trainer will need to have thought through what group norms and behaviors will be necessary during sessions and then communicate these to the group. These can be written on newsprint and posted on the wall ahead of time. For example, participants are to bring their copy of the TIP to every session; because of time constraints, punctuality is essential, etc. Ask the group for any group norms that might have been missed, but spend only a minute or two on this. Explain that because of the 45-minute time constraint, discussions of norms must be kept very brief. However, if the need for additional norms develops as the sessions proceed, participants should communicate with the trainer immediately before or after the session so that it may be brought up during the next session.
- ***Participant introductions:*** If participants are not from the same organization, take time to allow them briefly to introduce themselves. If there is a very large number of participants, time constraints require that different agencies or programs be introduced and people from that site simply stand by way of introduction.
  - If participants are from the same organization, simply have everyone give their name and department or area.

Introduction to TIP Training

Trainer Note:

- Provide a brief background of TIPs, Center for Substance Abuse Treatment (CSAT) and the Addiction Technology Transfer Centers (ATTC).

OH #1-2

- Treatment Improvement Protocols or TIPS are best-practice guidelines for the treatment of substance use disorders. These documents are developed by the Center for Substance Abuse Treatment (CSAT), which is part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (DHHS). To produce each TIP, CSAT draws on the experience and knowledge of clinical, research, and administrative experts in that particular topic area.

Trainer Note:

- Ask participants turn to page xi. Allow participants time to access the page.

- Please turn to page xi in your TIP. This is the Consensus Panel responsible for TIP 42.
- The companion training to this TIP was developed by the Mid-America Addiction Technology Transfer Center (ATTC) in consultation with TIP 42 Consensus Panel Chair, Stanley Sacks, PhD and Co-Chair, Richard Ries, MD.

OH #1-3

- The Mid-America ATTC is one of several regional centers that form the ATTC Network.
- The ATTCs, funded by SAMHSA/CSAT, are dedicated to upgrading the skills of existing practitioners and other health professionals and to disseminating the latest evidence based research to the treatment community.

OH #1-4

In This Module . . .

Trainer Note:

- ***Guided exploration and reading***—As part of this initial presentation, participants are intentionally required to flip back and forth to several chapters and appendices. This helps participants understand the range and potential usefulness of the material contained in the TIP. Trainers should both state and demonstrate that this training is not meant to replicate the TIP information but to explore the document itself and its potential utility to the participants.
  - Encourage participants as they go through the session to highlight, use Post-It notes, write or mark the text in any way that will make it more useful to them. Provide highlighters that participants can "borrow" during the session.
  - The scripted lecture allows the trainer to customize the amount of detail on various topics to the interests and needs of the audience. For example, the trainer may wish to mention some of the studies of interest to the audience and omit others. To assist in this effort, several types of bullets and degree of indentation provide cues to the trainer regarding content that is of primary, secondary and tertiary importance.
    - Primary importance
      - Secondary importance
        - Tertiary importance
  - It is essential that the trainer allow time for the participants to move from page to page during the presentation.

OH #1-5

- This first module is intended to provide us with:
  - An overview of the evolving field of co-occurring disorders (COD)
  - A review of the important developments that led to this TIP
  - An opportunity to explore TIP 42 and how it is organized

Trainer Note:

- Hold up TIP 42. Check that each participant has a copy of the TIP document.
- Explain that in this training, the TIP document will be used as a text and handled often. Participants need to bring their TIP 42 with them to every session.

- The clients that are the focus of this TIP and of our training are "persons with co-occurring disorders." We now even speak of an evolving "field" of co-occurring disorders. Many of us are familiar with terms previously used, such as a "dual diagnosis" or "dual disorder," as there have been many terms attempting to describe these clients.

TIP Exercise

Trainer Note:

- This exercise has several purposes. First, it is intended to ease participants who may not know each other into discussion, in this case with their neighbor. Second, it reinforces use of the text as the primary source of content. Third, the responses inform the trainer regarding the variety of terms for persons with COD that are familiar to the participants.

- Please open your TIP to page 27 in Chapter 2. Chapter 2 is dedicated to Definitions, Terms and Classification Systems for co-occurring disorders. *(Have participants turn to page 27 in the TIP. Wait until all have accessed the page.)*

OH #1-6

- On page 27, please read the left column. Then introduce yourself to the person beside you if you haven't met, and together answer the following:

  1. Which of these terms have you ever used or heard?
  2. Which of these terms are commonly used in your programs?
  3. What advantages might the term "co-occurring disorders" have over the terms "dual diagnosis" and "dual disorder"? Over some of the other terms?

  You will have four (4) minutes for this.

4 minutes

Trainer Note:

- Call time after four (4) minutes.
- Ask a couple of the dyads to report out.
- Include the larger group by asking for a show of hands as to how many have used or heard of the different terms mentioned.

What Does the Term "Co-Occurring Disorder" Mean?

OH #1-7

- We depend on terms in our communication, but as we have seen, there can be subtle differences in meaning. Clarification is important. Therefore, we need to define exactly what is meant by the term "co-occurring disorders."
- Please open your TIP to page 3, the introductory chapter, and look at the top left column. *(Wait for people to turn to the page, then show slide.)*
- For purposes of this training, "co-occurring disorders" refers to co-occurring substance use (abuse or dependence) and mental disorders.
- Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders.
- A diagnosis of co-occurring disorders (COD) occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder.

Discussion

Trainer Note:

- Following presentation of the definition of co-occurring disorders (COD), participants are asked to discuss and report on the questions below.
- The questions can be assigned to dyads or small groups to discuss for 2-3 minutes and then report out. Or the trainer can lead the discussion and ask participants for responses. The discussion is meant to help participants acknowledge the application of the training and the TIP to their work. These responses will also give the trainer insight into the needs of the participants and help guide future decisions regarding what to emphasize in each module and what to cut should time constraints require this.
- Encourage participants as they go through the session to highlight, use Post-It notes, write or mark the text in any way that will make it more useful to them. Provide highlighters that participants can "borrow" during the training session.

OH #1-8

1. Do these definitions describe clients you see in your practice/program? *(Estimate percentage or describe prevalence.)*
2. How has providing services to clients with COD affected your practice/ program?
3. What challenges do they present to your clinical knowledge and skills?

Trainer Note:

- Use responses from above discussion to segue into the next section.

- Despite developments in the area of co-occurring disorders, individuals with substance use and mental disorders commonly appear at facilities that are not prepared to treat them. They may be treated for one disorder without consideration of the other disorder, often "bouncing" from one type of treatment to another as symptoms of one disorder or another become predominant. Sometimes they simply "fall through the cracks" and do not receive needed treatment.
- This TIP captures the current state-of-the-art treatment strategies to assist counselors and treatment agencies in providing appropriate services to clients with COD.

20 minutes

The Evolving field of Co-Occurring Disorders

History and Implications of COD for Treatment Outcomes

- The emphasis on the relationship between substance use and mental disorders dates to the late 1970s, when practitioners increasingly became aware of the implications of these disorders, when occurring together, for treatment outcomes.
  - The association between depression and substance abuse was the subject of several early studies (e.g., Woody and Blaine 1979), but by the 1980s and 1990s, both the substance abuse and mental health communities found that a wide range of mental disorders were associated with substance abuse, not just depression (e.g., De Leon 1989; Pepper et al. 1981; Rounsaville et al. 1982*b*; Sciacca 1991).
  - Researchers not only found a link between substance abuse and mental illness, they also found the dramatic impact the complicating presence of substance abuse may have on the course of treatment for mental illness. That is, the likelihood of poorer outcomes for such clients in the absence of targeted treatment efforts (Drake et al. 1998*b*; Office of the Surgeon General 1999).
  - Research, such as the National Treatment Improvement Evaluation Study (NTIES) has demonstrated that substance abuse treatment of clients with co-occurring mental illness and substance use disorders can be beneficial-even for clients with serious mental disorders. (Note: The NTIES is 15 years old.)

OH #1-9

- The association between mental disorders and substance abuse has had implications for treatment.
  - Although many clients in traditional substance abuse treatment settings with certain less serious mental disorders than those described in NTIES appear to do well with traditional substance abuse treatment methods (Hubbard et al. 1989; Hser et al. 2001; Joe et al. 1995; Simpson et al. 2002; Woody et al. 1991), modifications designed to address those mental disorders can enhance treatment effectiveness and are essential in some instances.

- New models and strategies are receiving attention and encouraging treatment innovation (Anderson 1997; De Leon 1996; Miller 1994*a*; Minkoff 1989; National Advisory Council [NAC] 1997; Onken et al. 1997; Osher and Drake 1996). For example:
  - The American Society of Addiction Medicine (ASAM) added substantial new sections on clients with COD to an update of its patient placement criteria (ASAM 2001).
  - The National Association of State Alcohol and Drug Abuse Directors (NASADAD) joined with the National Association of State Mental Health Program Directors (NASMHPD) (NASMHPD-NASADAD 1999, 2000) and other collaborators in a series of national efforts designed to:
    - Foster improvement in treatment by emphasizing the importance of knowledge of both mental health and substance abuse treatment.
    - Provide a classification of treatment settings to facilitate systematic planning, consultations, collaborations, and integration.
    - Reduce the stigma associated with both disorders and increase the acceptance of substance abuse and mental health concerns as a standard part of healthcare information gathering.
- The association between mental disorders and substance abuse has also had implications for clinicians.
  - Knowledge of both mental health and substance abuse treatment has become essential in order to work effectively with clients for whom both issues are relevant.
  - Dissemination of knowledge has been widespread as evidenced by the increasing clinical attention to issues surrounding effective treatment for this population such as:
    - The large number of books and articles published on the topic, from counseling manuals and instruction (Evans and Sullivan 2001; Pepper and Massaro 1995) to database analysis of linkage among treatment systems and payors (Coffey et al. 2001).
    - The emergence of several annual "dual diagnosis" conferences.
- In spite of these developments, individuals with substance use and mental disorders commonly appear at facilities that are not prepared to treat them. This TIP captures the current state-of-the-art treatment strategies to assist counselors and treatment agencies in providing appropriate services to clients with COD.

OH #1-10

Why a new TIP on co-occurring disorders?

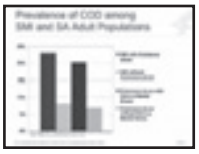
- These are some of the developments that led to publication of this TIP. We will look at them each more closely.
  - The availability of data regarding the prevalence of COD and the availability of other data related to COD
  - Emerging treatment innovation for populations with COD such as the homeless, offenders, people with HIV and other infectious diseases and people suffering from PTSD
  - Changes in treatment delivery
  - Advances in treatment
  - Recent developments

Availability of Prevalence and Other Data on COD

- National surveys suggest that COD are common in the adult population.

OH #1-11

- In 2002, 4 million adults met the criteria for both serious mental illness (SMI) and substance dependence and abuse (Office of Applied Studies [OAS] 2003*b*).
- According to the National Comorbidity Study (NCS) an estimated 10 million Americans of all ages and in both institutional and non-institutional settings have COD in any given year (Kessler et al. 1994, 1996*a*, *b*, 1997).



OH #1-12

- *The National Survey on Drug Use and Health* (NSDUH) also looked at the correlation between serious mental illness and substance use.
  - Among adults with SMI in 2002, 23.2 percent were dependent on or abused alcohol or illicit drugs, while the rate among adults without SMI was only 8.2 percent.
  - Among adults with substance dependence or abuse, 20.4 percent had SMI; the rate of SMI was 7 percent among adults who were not dependent on or abusing a substance.

OH #1-13

- As we have mentioned, data shows COD are common in the general adult population, though many individuals go untreated.
- Some evidence supports an increased prevalence of people with COD and of more programs for people with COD.
  - NASADAD conducts voluntary surveys of State Alcohol and Drug Abuse Agencies and produces the State Alcohol and Drug Abuse Profile (SADAP) reports. Information related to COD in these profiles suggests about a 10 percent increase in both the number of people with COD entering treatment and in the number of programs in many States over that 3-year period (Gustafson et al. 1999).
  - The 2002 National Survey of Substance Abuse Treatment Services (N-SSATS) indicated that about 49% of 13,720 facilities nationwide reporting substance abuse services offered programs or groups for those with COD compared to 44.7% in 1997 (OAS 2003*a*).
- Compared to people with mental or substance use disorders alone, people with COD are more likely to be hospitalized and the rate of hospitalization may be increasing.
  - According to Coffey and colleagues, the rate of hospitalization for clients with both a mental and a substance use disorder was more than *20 times the rate for substance abuse-only clients and 5 times the rate for mental disorder-only clients* (Coffey et al. 2001).
- Rates of mental disorders increase as the number of substance use disorders increase, further complicating treatment. The DATOS study on page 8 of your TIP provides a summary of some of these findings. (Note: The DATOS is 15 years old.)
- Please turn to the figure on page 8 of your TIP (#13). *(Wait as participants turn to page 8.)*

- This figure summarizes some of the information in the Drug Abuse Treatment Outcome Study (DATOS). Figure 1-2 shows a general trend of increase in the rates of lifetime antisocial personality disorder, major depression, and generalized anxiety disorder as the number of substance dependencies involving alcohol, heroin, and cocaine increase.
  - For example, under the drug dependency column for cocaine only, the rate for antisocial personality disorder is 30.4%. That rate of antisocial personality rises to 47% when cocaine is combined with alcohol dependency and to 59.8% when cocaine is combined with heroin and alcohol.
  - For heroin only, the rate of generalized anxiety is 2% but that rate rises to 3.2 % in cases of heroin and alcohol dependencies and to 6.3 % in cases of cocaine, heroin and alcohol dependencies.
- Notice that exceptions to this tendency occur between alcohol dependence only and major depression and generalized anxiety.
- Since the use of multiple drugs is common in those with substance use disorders, treatment is further complicated for these people by the greater incidence of mental disorders that accompanies multiple drug use.
- For those of us who may need more information on specific mental disorders such as antisocial personality, major depression and anxiety disorders, Chapter 8 provides a quick guide and Appendix D provides more in-depth guidance for the counselor.
- Please turn to page 325. *(Have participants turn to page 325. Allow all to access page.)*
- As itemized in the light purple box on the left, this appendix gives essential guidance to counselors regarding a wide range of disorders.

Trainer Note:

- ***ASK***—Which of these disorders are relevant to your practice?
- Call on two (2) or three (3) participants to share.

- For each disorder, the following topics are discussed:
  - Description of the disorder
  - Differential diagnosis
  - Prevalence
  - Substance use among people with this disorder
  - Key issues and concerns that arise in working with clients who have this disorder
  - Strategies, tools and techniques, including those relevant to engagement, assessment, crisis stabilization, short-term care and treatment, and longer-term care
- We will be using several of the case studies presented in future sessions.

Treatment Innovation for Other Populations with COD

Trainer Note:

- Refer back to Slide #1.10: "Why a new TIP on Co-Occurring Disorders?"

OH #1-14

- As we listed earlier, another reason for development of this TIP is the number of emerging treatment innovations for specialized populations with COD.
- Please turn to page 197 in your TIP to the section titled Specific Populations. *(Have participants turn to page 197 in TIP. Wait until participants have accessed the page.)*
- This is part of Chapter 7, which deals with Special Settings and Specific Populations. As you page through this section, notice that the TIP provides a variety of information on several specific populations including:
  - Homeless populations on page 197
  - Criminal Justice populations on page 200
  - Women on page 203

Trainer Note:

- Allow participants time to examine the sections.

- Also, notice the dark purple text boxes titled "Advice to the Counselor," like the one on page 200. *(Allow participants enough time to access page 200.)*
- These text boxes can be found throughout the TIP. This special feature provides a distillation of what the counselor needs to know and steps the counselor can take when working with clients that can be followed by a more detailed reading of the relevant material in the section or chapter.

Changes in Treatment Delivery

- Another reason for publication of a new TIP is that since the publication of TIP 9, the first TIP to address co-occurring disorders, the substance abuse treatment field has recognized the importance of COD programming.
  - In 1995, only 37% of the substance use disorder treatment programs reporting data to the Substance Abuse and Mental Health Services Administration (SAMHSA) offered COD programming. By 1997, this percentage had increased to almost 50% and this figure has remained relatively stable.

Advances in Treatment

- Advances in treatment are also evidence of the evolution of the field of co-occurring disorders and another reason for this TIP. Please turn to page 11 of your text. *(Have participants turn to page 11 in TIP 42. Wait until all have accessed page.)*

OH #1-15

- This section gives a brief overview of the most salient advances and refers to those chapters of the TIP where these topics are dealt with in depth. We will take a brief look at each of these now and examine them in greater detail in future sessions.
- ***"No wrong door" policy (p. 11)***—Of particular importance in these advances to treatment is the principle of "no wrong door." Every "door" in the healthcare delivery system should be the "right" door.
- According to this principle the healthcare delivery system, and each provider within it, has a responsibility to address the range of client needs wherever and whenever a client presents for care.
  - When clients appear at a facility that is not qualified to provide some type of needed service, those clients should be carefully guided to appropriate, cooperating facilities, with follow-up by staff to ensure that clients receive proper care.

- ***Mutual self-help for people with COD (p. 12)***—Based on the Alcoholics Anonymous model, the mutual self-help movement has grown to encompass a wide variety of addictions. These programs are discussed in greater detail in Chapter 7 of the TIP.
  - Though these typically are referred to as "self-help" groups, this TIP adopts the term "mutual self-help" because it is more descriptive of the way most participants see these groups-as a means of both helping themselves and supporting each other in achieving specific personal goals.
- ***Integrated care as a priority for people with severe and persistent mental illness (p. 12)***—For the purposes of this TIP, integrated treatment refers to any mechanism by which treatment interventions for COD are combined within the context of a primary treatment relationship or service setting.
- Integrated treatment is a means of coordinating substance abuse and mental health interventions to treat the whole person more effectively.
  - In a review of mental health center-based research for clients with serious and persistent mental illness, Drake and colleagues (1998*b*) concluded that comprehensive, integrated treatment, "especially when delivered for 18 months or longer, resulted in significant reductions of substance abuse and, in some cases, in substantial rates of remission, as well as reductions in hospital use and/or improvements in other outcomes" (p. 601).
  - Several studies based in substance abuse treatment centers addressing a range of COD have demonstrated better treatment retention and outcome when mental health services were integrated onsite (Charney et al. 2001; McLellan et al. 1993; Saxon and Calsyn 1995; Weisner et al. 2001).
- An integrated care framework supports the provision of some assessment and treatment wherever the client enters the treatment system, ensures that arrangements to facilitate consultations are in place to respond to client issues for which a provider does not have in-house expertise, and encourages all counselors and programs to develop increased competency in treating individuals with COD.
- This subject is explored further in Chapter 3, and some approaches to integrated treatment in substance abuse treatment settings are examined in Chapter 3 and Chapter 6.

- ***Development of effective approaches, models, and strategies (p. 13)***—Treatment approaches are emerging with demonstrated effectiveness in achieving positive outcomes for clients with COD. These include a variety of promising treatment approaches that provide comprehensive, integrated treatment.

- Successful strategies with important implications for clients with COD include interventions based on addiction work in contingency management, cognitive-behavioral therapy, relapse prevention, and motivational interviewing. These are discussed further in Chapter 5.

- It is now possible to identify "guiding principles" and "fundamental elements" for COD treatment in COD settings that are common to a variety of approaches. These are discussed at length in Chapter 3 and Chapter 6, respectively.

- Specific program models that have proven effective for the COD population with serious mental illness include Assertive Community Treatment (ACT) and the Modified Therapeutic Community (MTC). Intensive Case Management (ICM) also has proven useful in treating clients with COD. These are discussed in Chapter 6.

- ***Pharmacological advances (p. 13)***—Pharmacological advances over the past decade have produced antipsychotic, antidepressant, anticonvulsant, and other medications with greater effectiveness and fewer side effects.

- Increasingly, substance abuse treatment counselors and programs have come to appreciate the importance of providing medication to control symptoms as an essential part of treatment.

- Appendix F provides counselors with a handy reference on various psychotropic medications and their use. Please turn to Appendix F: Common Medications for Disorders on page 459. *(Have participants turn to page 459. Wait until all have accessed the page.)*

- Pages 459-462 provide a general overview. A feature that is of particular interest to most counselors begins on page 463. *(Have participants turn to page 463. Wait until all have accessed the page.)*

- Included in this appendix is an adaptation of the publication by the Mid-America Addiction Technology Center entitled *Psychotherapeutic Medications 2004: What Every Counselor Should Know.* Counselors have found this publication immensely useful. The beginning pages suggest practical strategies for the counselor when communicating with physicians as well as with clients.

Trainer Note:

- Allow participants time to peruse the section, *Psychotherapeutic Medications 2004: What Every Counselor Should Know.*

- Starting on page 465 is information on specific categories of these medications, such as antipsychotic medications, antidepressant medications, etc.
- Information for each category includes:
  - Generic and brand names
  - Purpose in treatment
  - Usual dose, frequency and side effects
  - Signs of emergency conditions
  - Cautions
  - Special considerations for pregnant women

Some Recent Developments

- Since the consensus panel for this TIP was convened, there have been several important developments in the field of COD.
- Please turn to page 14 of your text. *(Have participants turn to page 14 in TIP. Wait until all have accessed page.)*

OH #1-16

- Following is a description of the most recent developments in the field:
- ***National Registry of Effective Programs and Practices (p. 14)***—A resource to review and identify effective programs derived primarily from existing scientific literature, effective programs assessed by other rating processes, SAMHSA, and solicitations to the field.
- ***Co-Occurring Disorders State Incentive Grants (p. 14)***—Funded through SAMHSA's CSAT and Center for Mental Health Services (CMHS), these grants provide funding to the States to develop or enhance their infrastructure to increase their capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with COD.
- ***Co-Occurring Center for Excellence (p. 14)***—As a result of the pressing need to disseminate and support the adoption of evidence- and consensus-based practices in the field of COD, SAMHSA established the Co-Occurring Center for Excellence (COCE) in 2003. The COCE mission is to:
  - *Transmit* advances in substance abuse and mental health treatment that address all levels of mental disorder severity and that can be adapted to the unique needs of each client.
  - *Guide* enhancements in the infrastructure and clinical capacities of the substance abuse and mental health service systems.
  - *Foster* the infusion and adoption of evidence-based treatment and program innovation into clinical practice.
- ***Report to Congress on the Prevention and Treatment of Co-Occurring Substance Use Disorders and Mental Disorders (p. 15)***—A comprehensive report on treatment and prevention of co-occurring substance abuse and mental disorders provided in response to a Congressional mandate in December 2002 by the Department of Health and Human Services.
- ***Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit (p. 16)***—This resource package specifically targets clients with COD who have serious mental illness (SMI) and who are seeking care through mental health services available in their community. It was developed by the Psychiatric Research Center at New Hampshire-Dartmouth under the leadership of Robert E. Drake, MD, PhD, and is known simply as the "tool kit."

5 minutes

Wrap up

- As we have seen today, there is a great deal of valuable and practical information within this TIP. We will take a closer look at the specific chapters and appendices in our next sessions, but I encourage you to explore it for yourselves in between sessions. Then share with the rest of us what you have found particularly useful, or any questions you might have.

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 1

Substance Abuse Treatment for Persons with Co-Occurring Disorders Inservice Training

Based on A Treatment Improvement Protocol

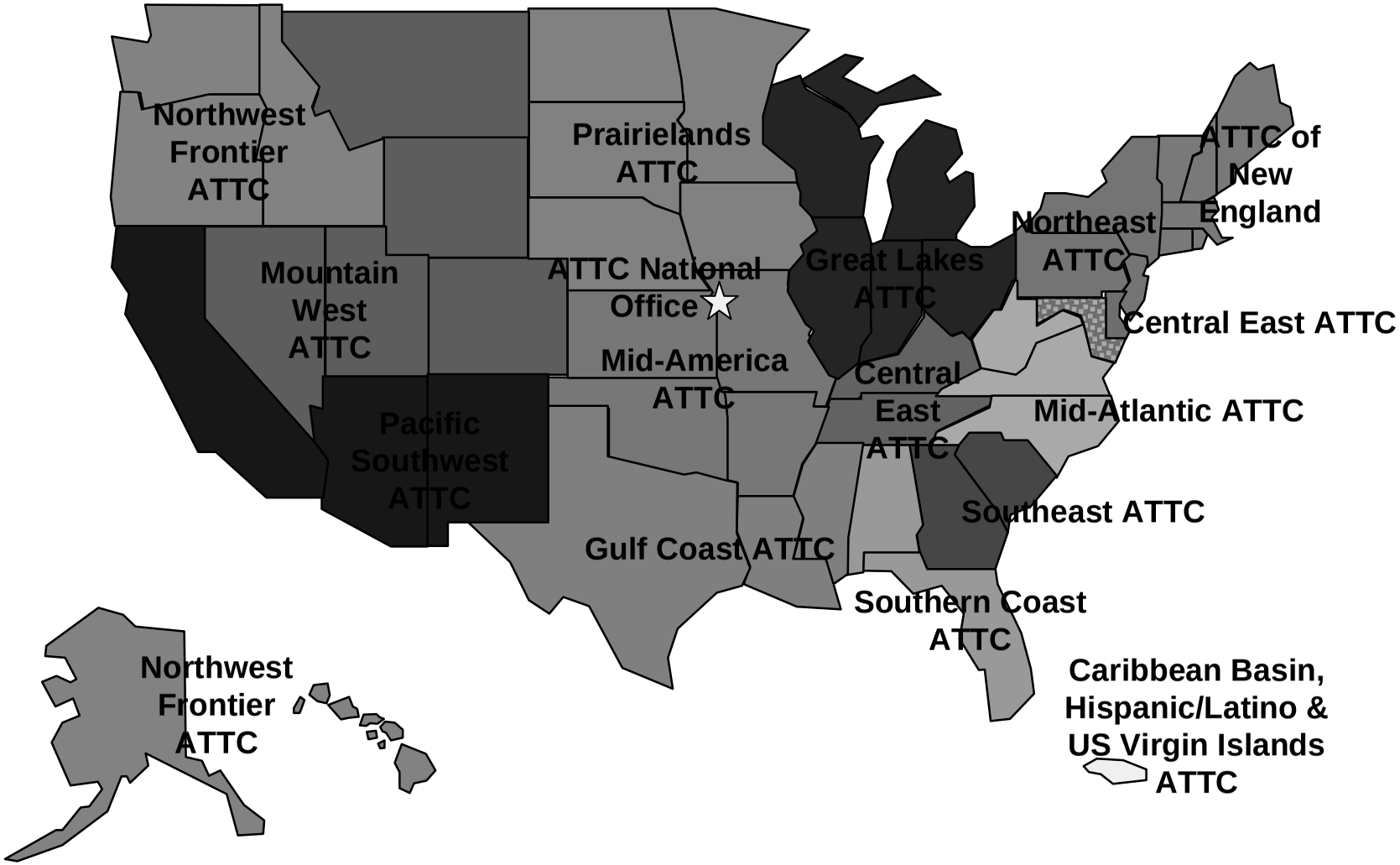
TIP 42

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

What is a TIP?

- Best-practice guidelines for treatment of substance use disorders
- Developed by Center for Substance Abuse Treatment (CSAT)
- Draws on experience and knowledge of clinical, research, and administrative experts in a particular topic area
- Consensus Panel for TIP 42, page xi

ATTC Network 2001-2006



Introduction—Module 1

The Evolving Field of Co-Occurring Disorders

In This Module . . .

- Overview of the evolving field of Co-Occurring Disorders
- Understanding of the important developments that led to TIP 42
- Initial exploration of TIP 42 and how it is organized

TIP Exercise—Terms

- Read the left column on Page 27
- Discuss with your partner:
  1. Which of these terms have you ever used or heard?
  2. Which of these terms are used in your programs?
  3. What advantages does the term “co-occurring disorders” have over “dual diagnosis” and “dual disorder”? Over the other terms?

Co-Occurring Disorders

Co-occurring disorders

- Refers to co-occurring substance use (abuse or dependence) and mental disorders.

Clients said to have co-occurring disorders have:

- one or more disorders relating to the use of alcohol and/or other drugs of abuse ***and*** one or more mental disorders.

Diagnosis of co-occurring disorders (COD) occurs when

- at least one disorder of each type can be established independent of the other ***and*** is not simply a cluster of symptoms resulting from the one disorder.

Co-Occurring Disorders:
Your setting

1. Do these definitions describe clients in your practice/program? *(Estimate percentage or describe prevalence)*
2. How has serving clients with COD affected your practice/program?
3. What challenges do clients with COD present to your clinical knowledge and skills?

Co-Occurring Disorders: *Implications*

- Treatment
  - Prevalence of COD, multiple problems they create, impact on treatment and treatment outcome, new models/strategies are receiving attention and encouraging treatment innovation
- Clinicians & Knowledge Dissemination
  - Knowledge of both mental health and substance abuse is essential and dissemination of knowledge has become widespread

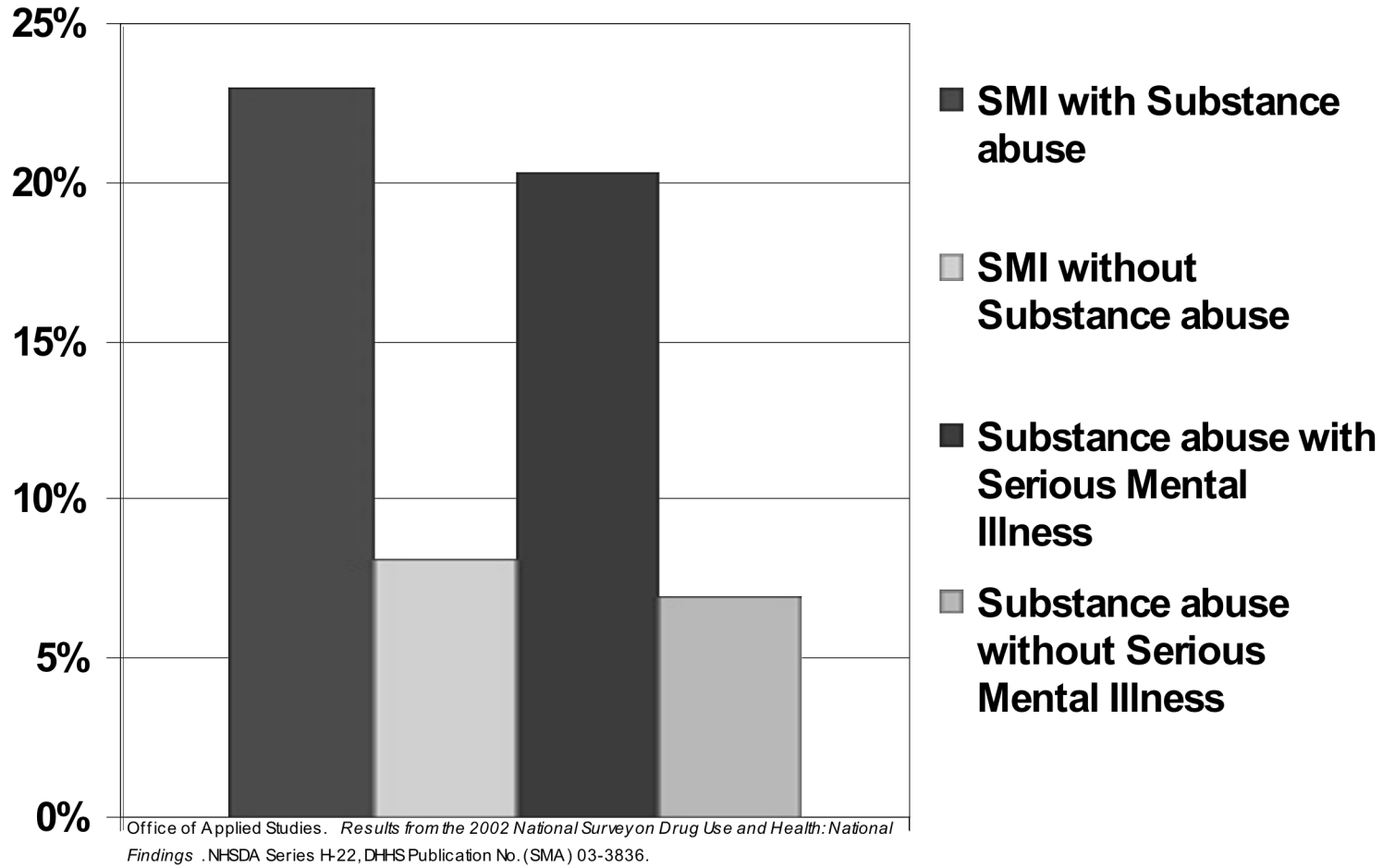
Why a new TIP on Co-Occurring Disorders?

- Availability of data
- Treatment innovations for other populations with COD
- Changes in treatment delivery
- Advances in treatment
- Recent developments

Prevalence of COD

- In 2002, 4 million adults met the criteria for both serious mental illness (SMI) and substance dependence and abuse.
- An estimated 10 million Americans of all ages and in both institutional and non-institutional settings have COD in any given year.

Prevalence of COD among SMI and SA Adult Populations



Office of Applied Studies. *Results from the 2002 National Survey on Drug Use and Health: National Findings* . NHSDA Series H-22, DHHS Publication No. (SMA) 03-3836.

Prevalence and Other Data

Data now show:

- COD are common in general adult population.
- Increased prevalence of people with COD and programs for people with COD.
- People with COD are more likely to be hospitalized and the rate may be increasing.
- Rates of mental disorders increase as the number of substance use disorders increase.

Why a new TIP on Co-Occurring Disorders?

- Availability of data
- Treatment innovations for other populations with COD
- Changes in treatment delivery
- Advances in treatment
- Recent developments

Advances in Treatment of COD

- “No wrong door” policy
- Mutual self-help for people with COD
- Integrated care as a priority for people with severe and persistent mental illness
- Development of effective approaches, models, and strategies
- Pharmacological advances

Recent Developments

- National Registry of Effective Programs and Practices (NREPP)
- Co-Occurring Disorders State Incentive Grants (COSIG)
- Co-Occurring Center for Excellence (COCE)
- Report to Congress on the Prevention and Treatment of Co-Occurring Substance Use Disorders and Mental Disorders
- Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit

MODULE 2: Definitions, Terms, and Classification Systems for Co-Occurring Disorders

Objectives

- The focus of this module is language, specifically terms related to various aspects of the field of co-occurring disorders. The trainer must keep in mind that the purpose of the module is to familiarize the participants with the following key terms and where to learn more about these in the TIP:
  - Substance use disorders
  - Mental disorders
  - Clients
  - Treatment
  - Programs
  - Systems

  Teaching the complex concepts that underlie these terms is beyond the scope of this brief module, but is addressed in subsequent modules.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Copies of the TIP ZIP test, one per participant *(See Handout section for master copy.)*
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 2.1-2.14
- Kitchen timer
- A copy of the DSM-IV-TR should participants not be familiar with it
- Markers and Post-It Notes for participants to use on their TIP texts
- Small reward such as candy, makers or other extrinsic reward for TIP ZIP test winners

Module Design

- ***Guided Exploration and Reading***—The trainer will guide the participants through the content of Chapter 2 in their copy of TIP 42. As mentioned earlier, there is more information than can be imparted in the time allowed; therefore, the trainer needs to adjust the presentation to the needs of the audience. Trainers must adapt the length of this section in order to allow full time for the discussion and report out of small groups.
- ***Discussion***—Brief exchanges with trainer as well as a small group discussion session are included in Module 2 (see Discussion Questions section below). Adapt the Guided Exploration and Reading section as needed to allow full time for the small group discussion.
  - There are several questions suggested throughout the script for the trainer to ask participants so they may connect content to their practice. These are meant to be brief exchanges.
  - Small group discussion takes place towards the end of the module. The trainer should anticipate how many groups are appropriate (3-5 participants) and how to break participants into groups in a way that is time efficient. For example, if participants are seated in rows, split rows by threes or fives to create groups, or have two people in one row pair up with the two people in the row directly in front of them, etc.

Suggested Timetable for Module 2

Introduction ■ Reconvening ■ In This Module ■ DSM-IV-TR	5 minutes
TIP ZIP Test	5 minutes
Lecture ■ Terms Related to Substance Use Disorders ■ Terms Related to Mental Disorders – Personality Disorders – Psychotic Disorders – Mood Disorders ■ Terms Related to Clients ■ Terms Related to Treatment – Levels of Service – Quadrants of Care – Integrated Treatment and Integrated Intervention – Culturally Competent Treatment ■ Terms Related to Programs ■ Terms Related to Systems	15 minutes
Discussion ■ Small Group Discussion—*5 minutes* ■ Report Out—*10 minutes*	15 minutes
Wrap up ■ TIP ZIP Test Review	5 minutes
TOTAL	**45 minutes**

5 minutes

OH #2-1

Introduction

Reconvening

Trainer Note:

- The facilitator will briefly remind participants about the last session and check to make sure all participants have access to a TIP 42 text. Lend copies or have people share.

- Last session we looked at how the field of co-occurring disorders has and continues to evolve. We also spent some time looking through the various sections of the TIP. Did anyone have a chance to examine it further? Were there any sections that we viewed last session that were particularly interesting to you?
- Module 2 focuses on our professional language, the language we see in the literature, the language we hear and use related to co-occurring disorders. The TIP can serve as a resource and reference in this regard.

OH #2-2

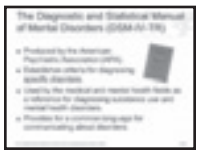
In This Module . . .

- In this module we will review and discuss the following key terms related to various aspects of the field of co-occurring disorders:
  - Substance Use Disorders
  - Mental Disorders
  - Clients
  - Treatment
  - Programs
  - Systems
- Some of these terms will be familiar, some may be new. Some terms may be familiar but we may not all define them in the same way. Some were developed by different groups for different purposes and therefore they do not form a seamless picture or always work smoothly together. Nevertheless, they are useful when used in the intended context.
- Our purpose in this session is to review key terms and where in the TIP you can learn more about them. The participant who becomes conversant with these terms and classifications will find it easier to navigate the discussion of treatment issues and to follow the TIP narrative.

DSM-IV-TR

Trainer Note:

- This brief description of the DSM-IV-TR text and its role in the COD field should include a copy of the manual which is held up and then passed around the room for participants to look at. If the trainer is certain that *all* participants are familiar with the DSM-IV-TR, this section can be excluded. However, if there is any doubt, the section should be presented.



OH #2-3

- The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition is produced by the American Psychiatric Association (APA). It is updated periodically. (The IV in the title refers to the update.)
- Because the DSM-IV-TR is the national standard for definitions of mental disorders, it is used in this TIP.
- The DSM-IV-TR:
  - Provides a common language for communicating about the disorders
  - Establishes criteria for diagnosing specific disorders
  - Is used for diagnosing substance use and mental disorders by the medical, mental health and substance abuse fields

5 minutes

TIP ZIP Test

Trainer Note:

- An initial activity, a TIP ZIP test, will focus participant attention. Each participant will need a copy. A master copy of the TIP ZIP test is included in the Handout section.
- Five (5) minutes is allowed for the test. Use a kitchen timer and enforce the time allowance.
- Participants may NOT use the TIP during the test taking. Participants may discuss their responses with their neighbor during the last two (2) minutes and change their responses if they wish.
- Once completed, tell participants that they will auto-correct their tests as responses will become evident during the session. Small prizes such as candy or markers can be given out at the end of the session to those with the most correct answers.

- To get us started today, we are going to take a little TIP ZIP test. The questions deal with some of the topics we will cover today. There are no grades, no penalties. You will have five (5) minutes to complete it, so don't agonize. It is just a way of focusing on our topic. So please close your TIP texts and do not peek. During the last two (2) minutes, you can check with your neighbor and change your responses if you wish. But you can't read the TIP yet.
- As we go through the module, we will have opportunity to check your responses and decide what the correct answer is. At the end of the session, we will take a final tally of our responses.

15 minutes

OH #2-4

Lecture

Terms Related to Substance Use Disorders

- The first terms we will examine are those related to substance disorders and we will cover them in more detail than the others. Please turn to page 22. *(Have participants turn to page 22.)*
- The criteria for a diagnosis of substance abuse appear in the light purple box at the bottom of the page. The criteria for diagnosis of substance dependence appear on the next page. Please review them for a moment. *(Allow time for all to access page and review.)*
- ***ASK***—How many of you use these DSM-IV-TR criteria to assess substance use disorders?

Substance Abuse—

- Substance abuse is described as a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (APA 2000, p. 198).
- Individuals who abuse substances may experience such harmful consequences of substance use as repeated failure to fulfill roles for which they are responsible, legal difficulties, or social and interpersonal problems.
- ***ASK***—Can a person have a diagnosis of substance abuse and substance dependence?

Trainer Note:

- *Answer:* Yes, if different classes of substances are involved. No, if the same class of drug is involved—per B on substance abuse diagnosis.

- Many considerations affect the amount of a substance needed to cause harm. For many individuals, such as those with severe mental disorders or traumatic brain injuries or developmental disabilities, the threshold of substance use that might be harmful, and therefore defined as abuse, might be significantly lower than for clients without these disorders.
  - The more severe the mental disorder, the lower the amount of substance use that might be harmful.

Substance Dependence—

- Substance dependence is more serious than abuse. This maladaptive pattern of substance use includes:
  - Increased tolerance for the drug or alcohol, resulting in the need for ever-greater amounts of the substance to achieve the intended effect.
  - The substance is often taken in larger amounts or over a longer period than was intended.
  - Persistence in using the drug or alcohol in the face of serious physical or mental health problems.
- ***ASK***—Does the development of tolerance to a substance satisfy the requirements for dependence?

Trainer Note:

- *Answer:* No, refer to diagnosis criteria. Tolerance is only 1 indicator and 3 are needed for a diagnosis of dependence.

Informal Usage—

- In your professional practice, how and when are these terms used? Are any other terms used?

Trainer Note:

- Elicit a couple of responses. Mention the following if needed:
  - "Substance abuse" is often used for both abuse and dependence.
  - "Addiction" is used for substance dependence.

Terms Related to Mental Disorders

- Although addiction counselors are not expected to diagnose mental disorders, they should familiarize themselves with the mental disorders that co-occur with substance use disorders and/or that mimic symptoms of substance use disorders, particularly withdrawal or intoxication.
- This section of the module briefly describes mental disorders that commonly co-occur with substance use disorders. More in-depth examination will take place in future sessions, most especially Module 8. You may also wish to examine Chapter 8 and Appendix D of your TIP, as well as the DSM-IV-TR for more information.

Personality Disorders

OH #2-5

- On page 24 is a brief overview of personality disorders. *(Have participants turn to page 24 and wait until all have accessed page.)*
- These individuals have personality traits that are persistent and cause impairment in social or occupational functioning or cause personal distress.
- Personality disorders are listed in the DSM-IV-TR under three (3) distinct areas, referred to as "clusters" and are described on page 24.
  - *Cluster A* traits involve odd or eccentric behavior. Cluster A includes paranoid, schizoid, and schizotypal personality disorders.
  - *Cluster B* traits involve dramatic, emotional, or erratic behavior. Cluster B includes antisocial, borderline, histrionic, and narcissistic personality disorders.
  - *Cluster C* traits involve anxious, fearful behavior. Cluster C includes avoidant, dependent and obsessive-compulsive personality disorders.
- Symptoms are evident in their thoughts (ways of looking at the world, thinking about self or others), emotions (appropriateness, intensity, and range), interpersonal functioning (relationships and interpersonal skills), and impulse control.
- Much of substance abuse treatment is target to those with antisocial personality disorder and substance abuse treatment alone has been especially effective for these disorders.

- ***ASK***—With a quick show of hands, which of these are most prevalent in your practice? Cluster A? Cluster B? Cluster C?
  - Research tells us that the prevalence of co-occurring substance abuse and antisocial personality disorder is high (Flynn et al. 1997).
  - Note that this section in your TIP includes an Advice to the Counselor box on working with clients who have antisocial personality disorder located on the bottom of page 24. Additional guidance on working with specific disorders can be found in Chapter 8 and Appendix D, which we will examine in future sessions.

Psychotic Disorders

OH #2-6

- On page 24 is the beginning of the section on psychotic disorders. *(Ensure that all participants have TIPs open to page 24.)*
- The common characteristics of these disorders are symptoms that center on problems of thinking. The most prominent (and problematic) symptoms are delusions or hallucinations. These are defined on page 25. *(Have participants access and refer to page 25.)*
  - Delusions are false beliefs that significantly hinder a person's ability to function. For example, a client may believe that people are trying to hurt him, or he may believe he is someone else (a CIA agent, God, etc.).
  - Hallucinations are false perceptions in which a person sees, hears, feels, or smells things that aren't real (i.e., visual, auditory, tactile, or olfactory).

Trainer Note:

- Clarify the difference between delusions and hallucinations using additional examples if needed. Then, continue training.

- Psychotic disorders are seen most frequently in mental health settings. When combined with substance use disorders, the substance disorder tends to be severe.
- Clients with psychotic disorders constitute what commonly is referred to as the serious and persistently mentally ill population.
- Delusions and/or hallucinations can also be secondary to drug intoxication (e.g., cocaine, methamphetamine, or phencyclidine) and psychotic-like symptoms may persist beyond the acute intoxication period.

Schizophrenia—

- Schizophrenia is one of the most common of the psychotic disorders. Symptoms may include the following: hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, social withdrawal, lack of interest, and poor hygiene.
- The disorder has several specific types depending on what other symptoms the person experiences. We will talk about the first two (2). You can read more about the others in the TIP Appendices on mental disorders.
  - In the paranoid type, there is a preoccupation with one (1) or more delusions or frequent auditory hallucinations that often are experienced as threatening to the person.
  - In the disorganized type, there is a prominence of all of the following: disorganized speech, disorganized behavior, and flat or inappropriate affect (i.e., emotional expression).

Mood Disorders

OH #2-7

- Mood disorders include those where the primary symptom is a disturbance in mood, where there may be inappropriate, exaggerated, or a limited range of feelings or emotions. For a client with a mood disorder, the feelings or emotions associated with the ups and downs of every day life are experienced to the extreme. There are several types of mood disorders:
  - ***Depression.*** Instead of just feeling "down," the client might not be able to work or function at home, might feel suicidal, lose his or her appetite, and feel very tired or fatigued. Other symptoms can include loss of interest, weight changes, changes in sleep and appetite, feelings of worthlessness, loss of concentration, and recurrent thoughts of death.
  - ***Mania.*** This includes feelings that would be more toward the opposite extreme of depression. There might be an excess of energy where sleep is not needed for days at a time. The client may be feeling "on top of the world," and during this time, the client's decision making process might be significantly impaired and expansive and he may experience irritability and have aggressive outbursts, although he might think such outbursts are perfectly rational.
  - ***Bipolar.*** A person with bipolar disorder cycles between episodes of mania and depression. Excessive use of alcohol is common during periods of mania.

- ***ASK***—With a quick show of hands, which of these is most prevalent in your practice?
- Many people with substance use disorders also have a co-occurring mood disorder and tend to use a variety of drugs in association with their mood disorder.

Anxiety disorders—

- An anxiety disorder exists when anxiety symptoms reach the point of frequency and intensity that they cause significant impairment. Anxiety disorders that may need particular assessment and treatment, are:
  - Social phobia (fear of appearing or speaking in front of groups)
  - Panic disorder (recurrent panic attacks that usually last a few hours, cause great fear, and make it hard to breathe)
  - Post-traumatic stress disorders or PTSDs (which cause recurrent nightmares, anxiety, depression, and the experience of reliving the traumatic issues)

OH #2-8

Terms Related to Clients

Person-Centered Terminology

- For many clients, it is more acceptable to be referred to as a person who has a specific disorder-a person with depression rather than "a depressive," a person with schizophrenia rather than "a schizophrenic," or a person who uses heroin rather than "an addict" because it implies that they have many characteristics besides a stigmatized illness, and therefore that they are not defined by this illness. *(Refer participants to page 26.)*
- This preference is respected in the TIP document and modeled in our training.

Terms for Co-Occurring Disorders

- As we discussed in Module 1 when we looked at the terms on page 27, many terms have been used in the field to describe the group of individuals who have COD. Often these have become too broad or varied in interpretation. For example, "dual diagnosis" also can mean having both mental and developmental disorders.
- The term "co-occurring disorder" is not inherently precise and distinctive and may also become distorted by popular use. However, the issue here is that clients/consumers may have a number of health conditions that "co-occur," including physical health problems. Nevertheless, for the purpose of the TIP, co-occurring disorders refers to substance use disorders and mental disorders.

Terms Related to Treatment

OH #2-9

Levels of Service

- Professionals in both mental health and in substance abuse treatment use scales and criteria to help guide client services. *(Have participants look on page 27 and page 28. Wait until all have accessed page.)*
- The American Society of Addiction Medicine's (ASAM) Patient Placement Criteria is one such scale (ASAM 2001). ASAM's criteria envision treatment as a continuum within which there are five (5) levels of care.

Quadrants of Care

Trainer Note:

- Have participants look at figures on page 29 and page 30. Wait until all have accessed the page. Then, continue training.

OH #2-10

- The Quadrants of Care classify clients in four (4) basic groups based on relative symptom severity, not diagnosis. Notice the "locus of care" for each of the quadrants.
  - Category I: Less severe mental disorder/less severe substance disorder
  - Category II: More severe mental disorder/less severe substance disorder
  - Category III: Less severe mental disorder/more severe substance disorder
  - Category IV: More severe mental disorder/more severe substance disorder (National Association of State Mental Health Program Directors [NASMHPD] and National Association of State Alcohol and Drug Abuse Directors [NASADAD] 1999)

- Fuller descriptions of each of these quadrants are in the text box on page 30.
- Most of the material in this TIP and this training is directed primarily to addiction counselors working in Quadrant III settings, and other practitioners working in Quadrant II settings.

Trainer Note:

- Review briefly descriptions of Quadrant II and Quadrant III. Then, continue lecture on terms related to treatment.

- Several other terms related to treatment are discussed on pages 28-32 and I encourage you to review those we do not address today. Terms that frequently appear in the current literature are integrated treatment and culturally competent treatment.

Integrated Treatment and Integrated Interventions

OH #2-11

- Integrated treatment refers broadly to any mechanism by which treatment interventions for COD are combined. Integrated interventions can be part of a single program or can be used in multiple program settings. Integrated treatment is a means of actively combining interventions intended to address substance use and mental disorders.

Culturally Competent Treatment

- Cultural competence may be viewed as a continuum on which, through learning, the provider increases his or her understanding and effectiveness with different ethnic groups.
- Cultural factors that may have an impact on treatment include heritage, history and experience, beliefs, traditions, values, customs, behaviors, institutions, and ways of communicating.
  - The client's culture may include distinctive ways of understanding disease or disorder, including mental and substance use disorders, which the provider needs to understand.
- It is important to remember that clients, not counselors, define what is culturally relevant to them. It is possible to damage the relationship with a client by making assumptions, however well intentioned, about the client's cultural identity. Counselors are advised to open a respectful dialog with clients around the cultural elements that have significance to them.

OH #2-12

Terms Related to Programs

Mental health-based programs—

- A mental health program is an organized array of services and interventions with a primary focus on treating mental disorders.
  - These programs may exist in a variety of settings, such as traditional outpatient mental health centers (including outpatient clinics and psychosocial rehabilitation programs) or more intensive inpatient treatment units.
  - Many mental health programs treat significant numbers of individuals with COD. Programs that are more advanced in treating persons with COD may offer a variety of interventions for substance use disorders (e.g., motivational interviewing, substance abuse counseling, skills training) within the context of the ongoing mental health treatment.

Substance abuse treatment programs—

- A substance abuse treatment program is an organized array of services and interventions with a primary focus on treating substance use disorders.
- Substance abuse treatment programs that are more advanced in treating persons with COD may offer a variety of interventions for mental disorders (e.g., psychopharmacology, symptom management training) within the context of the ongoing substance abuse treatment.

OH #2-13

Terms Related to Systems

- For the purposes of this TIP, *a system is a means of organizing a number of different treatment programs and related services to implement a specific mission and common goals*.
  - Single State Agencies are systems that organize statewide services. There may also be county, city, or local systems in various areas.

Substance Abuse Treatment System—

- The substance abuse treatment system encompasses a broad array of services organized into programs intended to treat substance use disorders (including illegal substances, such as marijuana and methamphetamine, and legal substances, such as alcohol).
  - It also includes services organized in accord with a particular treatment approach or philosophy (e.g., methadone treatment for opioid dependence or therapeutic communities).
- The primary focus of intervention is abstinence from illicit drugs for those who use illicit drugs and from alcohol for those who use alcohol excessively.

Mental Health Service System—

- The mental health service system includes a broad array of services and programs intended to treat a wide range of mental disorders.
- In most mental health systems, services are provided for a wide range of mental disorders; however, in many publicly financed mental health programs, the priority is on acute crisis intervention and stabilization and on the provision of ongoing treatment and rehabilitative services for individuals identified as having serious and persistent mental illness (SPMI).

15 minutes

OH #2-14

Discussion

Small Group Discussion

Trainer Note:

- To help participants connect terminology to their practice, create small groups of 3-5 people and ask the groups to discuss two (2) questions (below).
- For Question 1, assign each group a perspective (client's, clinician's or system's), alternating among the groups.
- Question 2 is intended to focus on terms participants want to learn more about. The trainer should highlight the importance of continued learning and encourage participants to read the TIP document on their own.
- Allow 5-7 minutes for discussion of both questions.

Question 1—

- ***ASK***—From a client, clinician, or system perspective: How does terminology help and hinder service to clients with co-occurring disorders?

Question 2—

- ***ASK***—Which of the terms mentioned are most useful to you? Which do you want to know more about?

Report Out

Trainer Note:

- Have groups report out. To expedite reporting, after the first group reports, ask if others with that same perspective had different responses. Probe, if necessary, to encourage discussion regarding the responses.
- For reports identifying terms that participants need or want to know more about, encourage further reading in the TIP or guide to appropriate resources.
- Allow 8-10 minutes for reporting out on both questions.

5 minutes

Wrap up

TIP ZIP Test Review

- Quickly review the TIP ZIP test key.
- Celebrate TIP ZIP test winners by offering a small reward such as candy, makers or other extrinsic reward.

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

Module 2
TIP ZIP TEST

1. A client presents with a history of having developed tolerance (as defined by a need for markedly increased amounts of the substance to achieve intoxication or desired effect). This meets the criteria for:
    a. Substance dependence
    b. Substance abuse
    c. Neither A nor B *(p. 23)*

2. A client presents with excessive energy, little need for sleep for days, and feelings that he is "on top of the world." These are potential signs of:
    a. Mood disorder
    b. Intoxication with stimulants
    c. Neither A nor B
    d. A and B *(pp. 26, 226, 229)*

3. "Suicidality" is a:
    a. Diagnosis
    b. Symptom *(p. 27)*

4. The type of COD client typically seen in the substance abuse system has:
    a. Less severe mental disorder/less severe substance disorder
    b. More severe mental disorder/less severe substance disorder
    c. Less severe mental disorder/more severe substance disorder
    d. More severe mental disorder/more severe substance disorder *(p. 29)*

5. T or F—Integrated interventions require the presence of both a mental health professional and a substance abuse treatment professional. *(p. 29)*

6. T or F—A client presents with the last name of Lopez and Hispanic appearance. Cultural competence dictates acknowledging that for such a client, family ties will be very strong and should be woven into the treatment plan. *(p. 31)*

7. T or F—The primary focus of interventions in the substance abuse treatment system is abstinence from illicit substances or alcohol. *(p. 34)*

8. T or F—The priority for the publicly funded mental health system is treatment and rehabilitation of individuals having serious and persistent mental illness. *(p. 34)*

Module 2
TIP ZIP TEST—*KEY*

1. A client presents with a history of having developed tolerance (as defined by a need for markedly increased amounts of the substance to achieve intoxication or desired effect). This meets the criteria for:
   a. ***Substance dependence***
   b. Substance abuse
   c. Neither A nor B *(p. 23)*

2. A client presents with excessive energy, little need for sleep for days, and feelings that he is "on top of the world." These are potential signs of:
   a. Mood disorder
   b. Intoxication with stimulants
   c. Neither A nor B
   d. ***A and B*** *(pp. 26, 226, 229)*

3. "Suicidality" is a:
   a. Diagnosis
   b. ***Symptom*** *(p. 27)*

4. The type of COD client typically seen in the substance abuse system has:
   a. Less severe mental disorder/less severe substance disorder
   b. More severe mental disorder/less severe substance disorder
   c. ***Less severe mental disorder/more severe substance disorder***
   d. More severe mental disorder/more severe substance disorder

   (p. 29)

5. T or ***F***—Integrated interventions require the presence of both a mental health professional and a substance abuse treatment professional. *(p. 29)*

6. T or ***F***—A client presents with the last name of Lopez and Hispanic appearance. Cultural competence dictates acknowledging that for such a client, family ties will be very strong and should be woven into the treatment plan. *(p. 31)*

7. ***T*** or F—The primary focus of interventions in the substance abuse treatment system is abstinence from illicit substances or alcohol. *(p. 34)*

8. ***T*** or F—The priority for the publicly funded mental health system is treatment and rehabilitation of individuals having serious and persistent mental illness. *(p. 34)*

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 2

Introduction

Definitions, Terms and Classification Systems for Co-Occurring Disorders

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

In This Module . . .

Review and discuss terms related to:

- Substance Use Disorders
- Mental Disorders
- Clients
- Treatment
- Programs
- Systems

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)

- Produced by the American Psychiatric Association (APA).
- Establishes criteria for diagnosing specific disorders.
- Used by the medical and mental health fields as a reference for diagnosing substance use and mental health disorders.
- Provides for a common language for communicating about disorders.

Terms Related to Substance Use Disorders

- Substance Abuse
- Substance Dependence
  - addiction

Terms Related to Mental Disorders Personality Disorders

***Cluster A*:**

- Involve *odd or eccentric behavior.*
- Includes *paranoid*, *schizoid*, and *schizotypal* personality disorders

Cluster B:

- Involve *dramatic, emotional, or erratic behavior.*
- Includes *antisocial, borderline, histrionic*, and *narcissistic* personality disorders

Cluster C:

- Involve *anxious, fearful behavior.*
- Includes *avoidant, dependent,* and *obsessive-compulsive* personality disorders

Psychotic Disorders

- Delusions
- Hallucinations
- These clients constitute what is commonly referred to as the serious and persistent mentally ill population
- Schizophrenia
  - Paranoid type
  - Disorganized type
  - Catatonic type
  - Undifferentiated type
  - Residual type

Mood and Anxiety Disorders

- Mood disorders
  - Depression
  - Mania
  - Bipolar disorder
- Anxiety disorders
  - Social phobia
  - Panic disorders
  - Post traumatic stress disorder (PTSD)

Terms Related to Clients

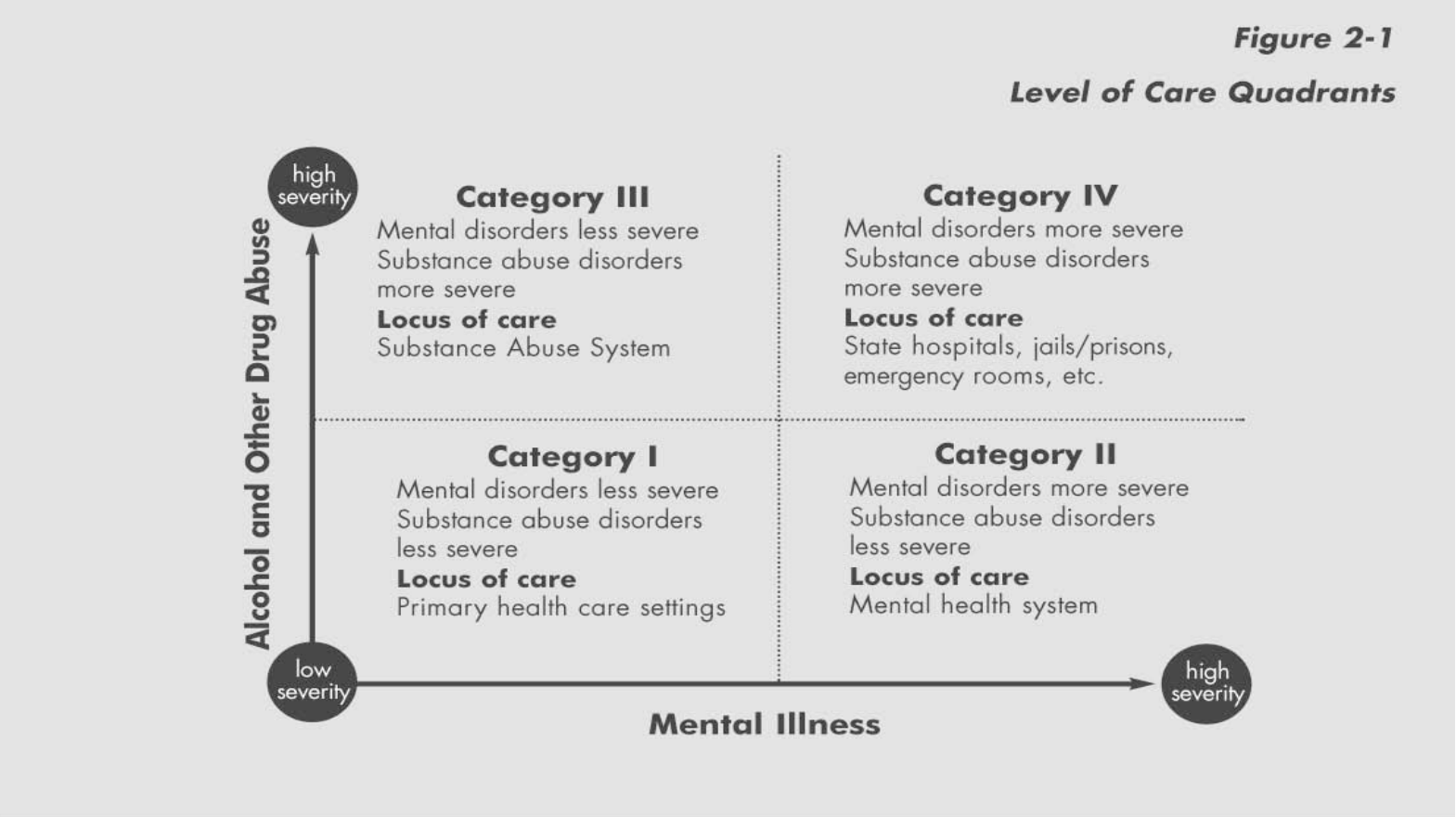
- Person-centered terminology
- Terms for co-occurring disorders
- Diagnosis vs. symptoms

Terms Related to Treatment Levels of Service

American Society of Addiction Medicine's Patient Placement Criteria	
Level 0.5	**Early Intervention**
Level I	**Outpatient Treatment**
Level II	**Intensive Outpatient/ Partial Hospitalization**
Level III	**Residential/ Inpatient**
Level IV	**Medically Managed Intensive Inpatient Treatment**

Source: ASAM 2001

Terms Related to Treatment Quadrants of Care



Terms Related To Treatment

- Interventions
- Integrated Interventions
- Episodes of Treatment
- Integrated Treatment
- Culturally Competent Treatment
- Integrated Counselor Competencies

Terms Related to Programs

Key Programs

- Mental health-based programs
- Substance abuse treatment programs

Program Types

- Addiction only services
- Dual diagnosis capable
- Dual diagnosis enhanced

Terms Related to Systems

- Substance Abuse Treatment System
- Mental Health Services System
- Interlinking Systems
- Comprehensive Continuous Integrated System of Care

Discussion

From a client or clinician or system perspective:

- How does terminology help and hinder service to clients with co-occurring disorders?
- Which of the terms mentioned are most useful to you? Which do you want to know more about?

MODULE 3A: Keys to Successful Programming: Guiding Principles and Core Components

Objectives

- The primary objective of Chapter 3 is to introduce participants to a framework agencies and practitioners can use when planning to serve clients with COD or trying to improve their existing services to this population.
  - ***Module 3A*** focuses on the fundamental building blocks of this framework, the *Six Guiding Principles in Treating Clients with COD and the Six Core Components* that form the ideal delivery of services.
  - *Module 3B* addresses the chapter's material on improving substance abuse treatment systems and programs, and it explores critical issues in workforce development and staff support.
- Secondary objectives of the module are to:
  - Establish participants as professionals whose experience and expertise make them valuable resources for one another
  - Deepen the interactions between the participants
  - Deepen the interactions between the participants and the TIP 42 text

Trainer Note:

- The following sections refer to Module 3A only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 3A.1-3A.6
- Kitchen timer
- Newsprint and markers for small group work
- Copy of the Handout, one per participant *(See Handout section for master copy).*

Module Design

- In Module 3A and 3B, participants engage in more thorough discussion with their peers regarding the TIP content and how it applies to their practice. The participants are recognized as expert resources for one another through the introduction of peer teaching activities (which will also be implemented in subsequent modules). Key interactions in this module are those between the participants and their peers and participants and the TIP document. The trainer's role is more that of a manager/facilitator.

Seating

- Participants should be seated in small groups of 3-5 people so that there are at least six (6) groups. Trainers should allow no more than five (5) people per group, and adaptations are scripted if there are more than six (6) groups. If the total number of participants is small, dyads may be used instead of small groups.
  - If the audience is a mix of front-line and administrative staff, the trainer should make sure the small groups consist of all administrators or all front-line staff as their discussion assignments will be different.

Suggested Timetable for Module 3A

Introduction ■ Reconvening and Discussion of Module 2 ■ Overview of Chapter 3 ■ In this Module ■ Guiding Principles ■ Delivery of Services Core Components – Empirical Evidence Related to Continuity of Care—*Optional*	6 minutes
TIP Exercise—Guiding Principles and Core Components ■ Assignment—*2 minutes* ■ Small Group Discussion—*15 minutes* ■ Report Out / Peer Teaching—*13 minutes*	30 minutes
Quick TIP Exercise—Levels of Program Capacity ■ Small Group Discussion—*5 minutes* ■ Report Out—*2 minutes*	7 minutes
Wrap up	2 minutes
TOTAL	**45 minutes**

6 minutes

OH #3A-1

Introduction

Reconvening and Discussion of Module 2

Trainer Note:

- Divide participants into small groups of 3-5 people so that you have at least six (6) groups. Distribute newsprint and markers to each table.
- If the audience is a mix of front-line and administrative staff, the trainer should make sure the small groups consist of all administrators or all front-line staff as their discussion assignments will be different.
- Check that everyone has a copy of the TIP. Lend copies or have people share.

- Last session we looked at definitions and terms related to the field of co-occurring disorders. Did you notice any of the terms or use them differently during your work week?
- We ended the session discussing terms we wanted to know more about. Did anyone have a chance to follow-up on those?

Overview of Chapter 3

- Chapter 3 in TIP 42 addressed the keys to successful programming for clients with COD. The information is designed to help agencies and practitioners planning to serve clients with COD or trying to improve existing services to this population.

OH #3A-2

- The material will be covered in two (2) modules:
  - ***Module 3A*** addresses the TIP's guidance regarding treatment and delivery of services to clients with COD.
  - *Module 3B* will look at the chapter's suggestions for improvement of substance abuse treatment systems and programs as well as issues in work force development and staff support.

In This Module . . .

OH #3A-3

- During our session today, we will examine the six (6) guiding principles in treating clients with COD. These principles were developed by the consensus panel and are derived from a variety of sources: conceptual writings, well-articulated program models, a growing understanding of the essential features of COD, elements common to separate treatment models, clinical experience, and available empirical evidence.
- While the guiding principles serve as the fundamental building blocks for effective treatment, *ensuring* effective treatment requires attention to other variables. In this module, we will also examine the six (6) core components for ideal delivery of services for clients with COD.

Guiding Principles

Trainer Note:

- Ask participants turn to page 38. Allow participants time to access the page.

- Please turn to page 38. In the text box at the bottom of the page are the six (6) Guiding Principles in treating clients with COD. The consensus panel responsible for this TIP used a wide variety of sources to develop principles that would serve as the fundamental building blocks for programs that offer services to clients with COD.
- These principles may be applied at both a program level (e.g., providing literature for people with cognitive impairments) or at the individual level (e.g., addressing the client's basic needs). The Six Guiding Principles in Treating Clients with COD are:

1. Employ a recovery perspective
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to treatment
4. Address specific real-life problems early in treatment
5. Plan for the client's cognitive and functional impairments
6. Use support systems to maintain and extend treatment effectiveness

Delivery of Services Core Components

OH #3A-4

- While the guiding principles are fundamental building blocks for effective treatment, delivering services effectively to clients with COD requires more.

Trainer Note:

- Ask participants turn to page 41. Allow participants time to access the page.

- Beginning on page 41, the TIP text discusses six (6) core components that form the ideal delivery of services for clients with COD. These are listed in the left column under the *Delivery of Services* heading and include:

1. Providing access
2. Completing a full assessment
3. Providing an appropriate level of care
4. Achieving integrated treatment
5. Providing comprehensive services
6. Ensuring continuity of care

Empirical Evidence Related to Continuity of Care—*Optional*

Trainer Note:

- If time allows, ask participants turn to page 47.
- Highlight for participants that evidence derived from research studies suggests this core component is beneficial.

- Evidence for the benefits of ensuring continuity of care comes from multiple sources.
  - Long-term outcomes from two (2) separate studies (Knight and colleagues 1999; Wexler and colleagues 1999) suggest the critical role of aftercare in maintaining positive treatment effects in the criminal justice population (although selection bias exists in these studies for entry into aftercare).
  - A study of homeless clients with COD provided further evidence (again with selection bias into aftercare) that aftercare is crucial to positive treatment outcomes (Sacks et al. 2003*a*).

30 minutes

TIP Exercise—Guiding Principles and Core Components

Trainer Note:

- This discussion is the means by which participants explore and integrate the six (6) guiding principles and the core components that form the ideal delivery of COD services in the context of their practice.
- Because this is the first opportunity for small group work, it sets the tone for small group activities in subsequent modules. It is important that the trainer make it enjoyable for participants and affirm the value of their professional experience and expertise in the teaching their peers.
- The most important aspect of the exercise is participant engagement with the text material and with peers, NOT the resulting report.
- Time management is essential in this module and use of a loud kitchen timer as a "neutral timekeeper" can help both trainer and participants stay on track.
- Make sure each participant has a copy of the handout (see Handout section).
- Assign one (1) guiding principle and one (1) core component to each small group (i.e., Principle 1 and Core Component 1 to one group, Principle 2 and Core Component 2 to another group, and so on).
- If there are more than six (6) groups, the same principle and component can be assigned to more than one (1) group. If there are few participants, form six (6) dyads instead of small groups.

Assignment

- Teaching others is one of the best ways to ensure we understand something. So, in this section, each group will become the expert on one (1) of the guiding principles and teach it to the rest of us. Each group will do the same with one (1) of the core components for effective delivery of services.
- As you can see on the slide and in your handout, there are six (6) principles and six (6) components. And, we have six (6) small groups. So, Group 1 will take Guiding Principle 1 and Core Component 1. Group 2, will take the second from both lists. Group 3 . . . *(continue with assignments).*

OH #3A-5

- Please follow along with your handout as we go over your instructions. As a group, I would like you to focus for a few minutes on the guiding principle assigned to you. In your small groups:
  - Review and then talk about your assigned guiding principle so that each of you are able to explain the principle in your own words, in a way that relates to your group's practice.
  - Discuss concrete examples of how you apply (or could apply) this principle in your practice or program. This will help the rest of us understand when you teach us your assigned principle.
- Then do the same for your assigned core component. Prepare to explain it in your own words. Decide if this is an area of strength or challenge for your agency and tell us why you think so.

Trainer Note:

- If groups are a mix of front-line staff and administrators, make the following adaptations to the assignment:
  - ***Front-line Staff Groups***—examine the principle and the component from the perspective of your individual practice.
  - ***Administrator Groups***—examine the questions from the perspective of your program.

- Each group will then teach their assigned guiding principle and core component to the rest of us in a two (2) minute report. Remember, you will use your own words and examples, not the text's.
- You will have 15 minutes for this activity and two (2) minutes to report out. There is newsprint and markers on your table should you want to create a visual for the presentation.
- Remember to designate who will present for your group. Any questions?

Small Group Discussion

Trainer Note:

- Set kitchen timer for 15 minutes and keep to time limits.
- Move from group to group to make sure participants have understood your directions and are on task.
- Warn participants after five (5) minutes and suggest they move on to their core component.
- Give a two (2)-minute warning to wrap up discussion.
- Call time after 15 minutes and begin reports.

Report Out / Peer Teaching

Trainer Note:

- Establish a positive tone for this activity. Introduce each group with a little flourish, and applaud after each presentation.
- Begin with the first guiding principle and core component report; then continue in order. If more than one (1) group was assigned the same principle and component, have one (1) group report out first and then ask the other group if they have anything to add.
- Allow only two (2) minutes for each presentation.
- Probe groups, if needed, for examples and insights from their discussion. They should explain using their own words.
- If there are less than six (6) groups, the trainer can briefly review the unassigned guidelines and core components from the text following the report out / peer teachings.

7 minutes

Quick TIP Exercise—Levels of Program Capacity

Trainer Note:

- This exercise allows participants to consider and briefly discuss the consensus panel's classification system in relation to their own program's level of capacity in co-occurring disorders.
- Allow five (5) minutes for discussion and two (2) minutes for brief report out.
- This exercise can be skipped if additional time is needed for the previous TIP Exercise on Guiding Principles and Core Components and reporting out.

- For our last activity today, I would like to go back to Figure 3-2 on page 44. *(Allow participants time to access page 44.)* Figure 3-2 depicts a model of basic, intermediate (COD capable), and advanced (COD enhanced) programming within mental health services and substance abuse treatment systems.
- The idea of integrated COD treatment is shown in the center. For the purpose of this TIP, both mental health and substance abuse treatment providers may be conceived as beginning, intermediate, or advanced in terms of their progress toward the highest level of capacity to treat persons with COD, although not all services want or need to be fully integrated.
- A brief description of each of these levels is in the left column on page 43.

Small Group Discussion

OH #3A-6

- With your group, I would like you to think about Figure 3-2 on page 44 and the explanatory text on page 43. Then decide where on the graph would you place your agency? Why?
- You will have five (5) minutes for this activity.

Report Out

- ***ASK***—Using a show of hands, how many of you think your agency is at the basic or beginning stage? The intermediate or COD capable stage? The advanced or COD enhanced stage?
- ***ASK***—Would any group like to explain why you placed their agency at that level?

2 minutes

Wrap up

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

Module 3A
TIP Exercise—PRINCIPLES AND CORE COMPONENTS

Guiding Principles for Effective Treatment *(starts on page 38)*		***Core Components for Effective Delivery of Services*** *(starts on page 41)*
Employ a recovery perspective	1	Providing Access
Adopt a multi-problem viewpoint	2	Completing a full assessment
Develop a phased approach	3	Providing an appropriate level of care
Address real-life problems early	4	Achieving integrated treatment
Plan for cognitive and functional impairments	5	Providing comprehensive services
Use support systems to maintain and extend treatment effectiveness	6	Ensuring continuity of care

Directions:
As a group review and then prepare to teach the rest of us your assigned Guiding Principle and Core Component.

1. In your own words, explain your assigned Guiding Principle.

    a. Give examples of how you apply (or need to apply) this principle in your practice or program.

2. In your own words, explain your assigned Core Component.

    a. Is this an area of strength or challenge for your agency? Explain.

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Module 3A

Introduction

Keys to Successful Programming:
Guiding Principles and Core Components

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TIP Chapter 3

- **Module 3A**
  - Guiding principles in treatment
  - Core components in delivery of services

- Module 3B
  - Improving substance abuse treatment systems and programs
  - Workforce development and staff support

In This Module . . .

Effective Treatment

- Guiding Principles for effective treatment of clients with COD

Effective Delivery

- Core Components for ideal delivery of services for clients with COD

Delivery of Services
Core Components

Guiding Principles for Effective Treatment		***Core Components for Effective Delivery of Services***
Employ a recovery perspective	**1**	Providing Access
Adopt a multi-problem viewpoint	**2**	Completing a full assessment
Develop a phased approach	**3**	Providing an appropriate level of care
Address real-life problems early	**4**	Achieving integrated treatment
Plan for cognitive and functional impairments	**5**	Providing comprehensive services
Use support systems to maintain and extend treatment effectiveness	**6**	Ensuring continuity of care

TIP Exercise—Guiding Principles & Core Components

1. In your own words explain your assigned Guiding Principle.
   - Give examples of how you apply (or need to apply) this principle in your practice or program.
2. In your own words explain your assigned Core Component.
   - Is this an area of strength or challenge for your agency? Explain.

(15 minutes)

Quick TIP Exercise—
Levels of Program Capacity

With your group

1. Review Figure 3-2 on page 44 and explanatory text on page 43 *(left column).*
2. Where on the graph would you place your agency? Why?

(5 minutes)

MODULE 3B: Keys to Successful Programming: Improving Substance Abuse Treatment Systems and Programs, and Workforce Development and Staff Support

Objectives

- The primary objective of Chapter 3 is to introduce participants to a framework agencies and practitioners can use when planning to serve clients with COD or trying to improve their existing services to this population.
  - *Module 3A* focuses on the fundamental building blocks of this framework, the *Six Guiding Principles in Treating Clients with COD and the Six Core Components* that form the ideal delivery of services.
  - ***Module 3B*** addresses the chapter's material on improving substance abuse treatment systems and programs, and explores critical issues in workforce development and staff support.

Trainer Note:

- The following sections refer to Module 3B only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 3B.1-3B.7
- Kitchen timer

Module Design

- Much of Module 3B focuses on informal self-assessment exercises and discussion as participants thoroughly explore how the TIP content applies to their practice. The self-assessment activities are highly introspective requiring each participant to interact directly with the TIP document. Participants are to assess themselves as outside observers would, in other words, based on their observable behavior. This activity and future discussion about the process will segue into Module 4—Assessment.

Seating

- Participants will work briefly with partners on the final self-assessment. If the number of participants is large, the trainer may wish to have participants sit in small groups. Scripted instances where the trainer interacts with the larger group could be carried out instead by assigning the questions to small groups and then asking for the group's general response. This will facilitate participation.

Suggested Timetable for Module 3B

Introduction ■ Reconvening and Review of Module 3A ■ Introduction to Module 3B	5 minutes
Improving Substance Abuse Treatment Systems and Programs	5 minutes
Workforce Development and Staff Support ■ Introduction	1 minute
Attitudes and Values ■ Introduction—*1 minute* ■ TIP Exercise—Attitudes and Values Self-Assessment – Set up—*1 minute* – Assessment—*3 minutes* – Discussion—*5 minutes*	10 minutes
Clinician Competencies—Basic ■ Introduction—*1 minute* ■ TIP Exercise—Basic Competencies Self-Assessment – Set up—*1 minute* – Assessment—*5 minutes* – Discussion—*5 minutes*	12 minutes
Competency Levels and Continued Professional Development	2 minutes
Avoiding Burnout and Reducing Staff Turnover ■ Introduction—*1 minute* ■ TIP Exercise—Avoiding Burnout Self-Assessment – Set up—*1 minute* – Assessment—*3 minutes* – Partner Discussion—*3 minutes*	8 minutes
Wrap up	2 minutes
TOTAL	**45 minutes**

5 minutes

OH #3B-1

OH #3B-2

Introduction

Reconvening and Review of Module 3A

Trainer Note:

- Check that everyone has a copy of the TIP. Lend copies or have people share.
- Briefly review Module 3A. Then, introduce Module 3B.

- Last session we worked in small groups and examined some of the keys to successful programming. These included the *Six Guiding Principles for Effective Treatment.* Do you remember which principle you worked on? Raise your hand when I call out the principle you were assigned.

  1. Employ a recovery perspective
  2. Adopt a multi-problem viewpoint
  3. Develop a phased approach to treatment
  4. Address specific real-life problems early in treatment
  5. Plan for the client's cognitive and functional impairments
  6. Use support systems to maintain and extend treatment effectiveness

- We also looked at some of the core components for the effective delivery of services.

  1. Providing access
  2. Completing a full assessment
  3. Providing an appropriate level of care
  4. Achieving integrated treatment
  5. Providing comprehensive services
  6. Ensuring continuity of care

Introduction to Module 3B

OH #3B-3

- Today we will continue our exploration of Chapter 3 in TIP 42. First, we will briefly examine the chapter's guidance for improving substance abuse treatment systems and programs. Then we will examine issues related to workforce development and staff support.

5 minutes

Improving Substance Abuse Treatment Systems and Programs

Trainer Note:

- Ask participants turn to page 48. Allow participants time to access the page.

OH #3B-4

- There are many challenges facing substance abuse treatment systems and programs intent on improving care for clients with COD. These include:
  - How to organize a system that will provide continuity of care for these clients who often have multifaceted needs and require long-term treatment plans.
  - How to access funding for program improvement.
  - How best to integrate research and practice to give clients the benefit of the proven treatment strategies.
- Beginning on page 48, the TIP addresses each of these major concerns in turn and provides guidance in addressing them. I would like to point out some of these to you. *(Ask participants to follow along on page 48.)*
- In the section, *Assessing the Agency's Potential to Serve Clients with COD*, the text discusses the need for agency self-assessment and the many benefits and uses of the resulting data.
- On page 49 in Figure 3-4, the text gives an example of how one collaborative project crossed agency lines to share resources among a variety of partners and ensure continuity of care.
- Please turn to page 51. *(Allow participants time to access the page.)* Figure 3-5 in the text box provides a list of questions to guide agencies in assessing their potential to serve clients with COD. In carrying out such an assessment, an agency will use the best approach possible given its resources. It may, for example, need to use estimates rather than precise data.

Trainer Note:

- ***ASK***—Which of these questions do you think your agency could readily find answers for? Which might your agency have to estimate?

- Starting on page 50, the text provides general guidance regarding *Accessing Funding* and discusses *Federal Funding Opportunities* on page 52, as well as *State and Private Funding Opportunities*.
- The text then tackles the challenges in *Attaining Equitable Allocation of Resources* on page 53.
- The section concludes on page 54 and 55 with a discussion regarding *Integrating Research and Practice* and *CSAT's Practice Improvement Collaboratives*.

1 minute

Workforce Development and Staff Support

Introduction

- In the introduction to this chapter, the text explains that regardless of what other systemic changes are made, without a well-prepared staff, the needs of clients with COD cannot be met. Beginning on page 55, the consensus panel has dedicated a section to the important issues of workforce development and staff support. Please turn to page 55. *(Allow participants to access page 55.)*
- This section addresses several topics including:
  - The attitudes and values needed to successfully treat clients with COD
  - Essential competencies at basic, intermediate and advanced levels
  - Paths to professional development for those who wish to increase their skills
  - Ways of avoiding staff burnout and reducing turnover—an especially pressing concern for providers who work closely with this population
- This section is specifically designed as a resource for you. We will spend time today thinking and talking about these issues and your work with clients with COD. However, we will only have time to introduce this information and encourage you to go back and explore it for your own benefit.

10 minutes

Attitudes and Values

Introduction

- The text addresses attitudes and values first. Attitudes and values determine how the provider views the client. They guide the way providers meet client needs and affect the overall treatment climate. Assumptions resulting from provider attitudes and values not only affect the standard of care a client will receive, but also profoundly influence how the client feels as he or she experiences a program.

Trainer Note:

- Ask participants to turn to page 57 and allow time to access the page.

- In the text box (Figure 3-7) the consensus panel has provided us a list of the E*ssential Attitudes and Values for Working with Clients Who Have COD*.
  - These were adapted from Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practic*e (Center for Substance Abuse Treatment 1998*a*).

OH #3B-5

TIP Exercise—Attitudes and Values Self-Assessment

Set up

- During the next few minutes, you will take some time to review this list in relation to your own attitudes and values regarding your work with clients with COD.
- This will be an informal self-assessment. I will not ask you to reveal your results, but we will discuss the process when you are finished.
- However, there is a little twist. I would like you to assess yourself based on your observable behavior, in other words, the way you think an outside evaluator would assess you, based only on what you say and what you do.
- For those of you who are administrators, depending on your responsibilities you may wish to respond regarding your own behavior or based on how an outsider would assess the overall observable behavior of those you supervise.
- You can just pencil in one (1) of the suggested symbols next to the item right in your text: a plus sign if you feel this is an area you excel in, a minus sign if it is an area you need to work on, and OK if your performance is adequate.
- Answer quickly as your first response is usually the most honest.

Trainer Note:

- Allow three (3) minutes for completion of assessment.
- Following the assessment, engage participants in brief discussion using some or all of the questions below. Allow no more than five (5) minutes for discussion.
- If there are many participants, assign the questions—one (1) per small group. Then briefly ask for resulting responses.

- ***ASK***—What additions or deletions would you make to the list?
- ***ASK***—How difficult was it to assess yourself based on how your observable behavior would appear to an outsider? What surprised you about the results?
- ***ASK***—How accurately do you think observable behavior reflects a person's attitudes and values regarding work with COD?

12 minutes

Clinician Competencies—Basic

Trainer Note:

- Ask participants to turn back to page 56; allow time to access the page.

Introduction

- The next area your text addresses on page 56 is clinician competencies. Clinicians' competencies are the specific and measurable skills that counselors must possess.
  - Several states, university programs, and expert committees have defined the key competencies for working with clients with COD.
- The consensus panel recommends viewing competencies as basic, intermediate, and advanced to foster continuing professional development of all counselors and clinicians in the field of COD. We will examine these briefly but your text describes each of these categories in greater detail.
- Every substance abuse treatment and mental health service program should require counselors to have certain basic skills. For clinicians working in substance abuse treatment settings, the consensus panel recommends that they should be able to carry out the mental-health-related activities shown on page 58 in Figure 3-8. Please turn to page 58. *(Allow participants to access page 58.)*

OH #3B-6

TIP Exercise—Basic Competencies Self-Assessment

Set up

- Again, we will take a few minutes to have you review these basic competencies in relation to your own work with clients with COD.
- I would like you to assess yourself based on your observable behavior, in other words, the way you think an outside evaluator would assess your competency, based on your performance. For any activities you do not usually perform, imagine how you would carry them out today, and how an outside evaluator would perceive your performance.
- For those of you who are administrators, depending on your responsibilities you may wish to respond regarding your own behavior or based on how an outsider would assess the overall observable behavior of those you supervise.
- Pencil in one (1) of the suggested symbols next to the item right in your text.
- Answer quickly as your first response is usually the most honest.

Trainer Note:

- Allow five (5) minutes for completion of assessment.
- Following the assessment, engage participants in brief discussion using some or all of the questions below. Allow no more than five (5) minutes for discussion.
- If there are many participants, assign the questions—one (1) per small group. Then briefly ask for resulting responses.

- ***ASK***—What surprises you about this list? What additions or deletions would you make?
- ***ASK***—How difficult was it to assess yourself based on how your observable behavior would appear to an outsider? What surprised you about the results?
- ***ASK***—How do these staff competencies (or lack of them) affect treatment? The work environment? How do they affect fidelity to program goals and methods?

2 minutes

Competency Levels and Continued Professional Development

Trainer Note:

- Briefly point out the sections on intermediate and advanced competencies.
- Briefly point out the section on continuing professional development.

- The text also discusses and provides examples of competencies at the intermediate and advanced level on pages 59 and 60. *(Allow participants to access pages.)* Please review these at your convenience.
- Beginning on page 57 the text discusses a wide variety of mechanisms counselors can use to enhance their professional knowledge and development. *(Allow participants to access page 57.)*
- Appendix I on page 513 also identifies useful sources of training. *(Allow participants to access page 513.)*

8 minutes

Avoiding Burnout and Reducing Staff Turnover

Introduction

- Our final topic for this session begins on page 62 and deals with avoiding burnout and reducing staff turnover. *(Allow participants to access page 62.)*
- Assisting clients who have COD is difficult and emotionally taxing; the danger of burnout is considerable. As clinicians are expected to manage growing and more complex caseloads, "compassion fatigue" may occur. This can occur when the pressures of work erode a counselor's spirit and outlook and begin to interfere with the counselor's personal life (see TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* [CSAT 2000*d*], p. 64).
- It is especially important that program administrators maintain awareness of the problem of burnout and the benefits of reducing turnover. It is vital that staff feel that program administrators are interested in their well-being in order to sustain morale and esprit de corps.
- To lessen the possibility of burnout when working with a demanding caseload that includes clients with COD, the TIP (CSAT 2000*d*, p. 64) provides some suggestions listed on page 62. These are bulleted in the right column.
  - Work within a team structure rather than in isolation.
  - Build in opportunities to discuss feelings and issues with other staff who handle similar cases.
  - Develop and use a healthy support network.
  - Maintain the caseload at a manageable size.
  - Incorporate time to rest and relax.
  - Separate personal and professional time.

OH #3B-7

TIP Exercise—Avoiding Burnout Self-Assessment

Set up

- For each item bulleted on page 62 assess how well you take care of yourself by complying with these recommendations.
- Select the two (2) that are most problematic. With a partner, take turns discussing why these recommendations are difficult and what alternatives you might consider to take better care of yourself.

Trainer Note:

- Allow three (3) minutes for completion of assessment.
- Allow at least three (3) minutes for partner discussions.
- Depending on time constraints, ask partner teams to volunteer to share their most problematic area and suggested solutions.

---

2 minutes

Wrap up

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

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Module 3B

Introduction

Keys to Successful Programming:
Improving Substance Abuse Treatment Systems & Programs and Workforce Development & Staff Support

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Delivery of Services
Core Components

Guiding Principles for Effective Treatment		***Core Components for Effective Delivery of Services***
Employ a recovery perspective	**1**	Providing Access
Adopt a multi-problem viewpoint	**2**	Completing a full assessment
Develop a phased approach	**3**	Providing an appropriate level of care
Address real-life problems early	**4**	Achieving integrated treatment
Plan for cognitive and functional impairments	**5**	Providing comprehensive services
Use support systems to maintain and extend treatment effectiveness	**6**	Ensuring continuity of care

TIP Chapter 3

- Module 3A
  - Guiding principles in treatment
  - Core components in delivery of services

- **Module 3B**
  - Improving substance abuse treatment systems and programs
  - Workforce development and staff support

Improving Substance Abuse Treatment Systems & Programs

Challenges include:

- How do we organize a system that will provide continuity of care?
- How do we access funding for program improvement?
- How do we integrate research and practice to give clients the benefit of proven treatment strategies?

TIP Exercise—Attitudes & Values Self-Assessment

For each item in Figure 3-7 (p. 57) assess yourself based on your observable behavior, the way you think an outside evaluator would assess you.

+	Excels in this area
-	Needs to work on
OK	Adequate

(3 minutes)

TIP Exercise—Basic Competencies Self-Assessment

For each item in Figure 3-8 (p. 58) assess yourself based on your observable behavior, the way you think an outside evaluator would assess you

+	Excels in this area
-	Needs to work on
OK	Adequate

(5 minutes)

TIP Exercise—Avoiding Burnout Self-Assessment

For each item bulleted on page 62 assess how well you take care of yourself by complying with these recommendations

+	Excels in this area
-	Needs to work on
OK	Adequate

Which two are most difficult?

(3 minutes)

MODULE 4A: Assessment: Screening, Step 1 and Step 2

Objectives

- Chapter 4 in the TIP presents an approach to comprehensive assessment of clients with COD and has as its purpose to encourage the field to move toward this ideal. In order to adequately address the chapter's main topics of screening and assessment, Module 4 has been designed as a cluster of three (3) 45-minute sessions that build on one another: Module 4A, Module 4B and Module 4C.
  - ***Module 4A*** addresses screening and Step 1 and Step 2 of the assessment process.
  - *Module 4B* examines Step 3 through Step 7 of the assessment process.
  - *Module 4C* examines Step 8 through Step 12 of the assessment process.

Trainer Note:

- The following sections refer to Module 4A only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 4A.1-4A.8
- Kitchen timer
- Markers and Post-It Notes for participants to use on their TIP texts

Module Design

- This module introduces a three-module presentation of the TIP's 12 steps in the assessment process. Module 4A is a blend of discussion, brief lecture, activity, and constant interaction with the TIP text. Discussions are either trainer-led or occur in participant dyads. Trainer-led discussions are intended to: (1) help participants briefly explore aspects of client assessment (e.g., common instruments, protocols), and (2) allow participants to *experience* what it is like for the counselor and client in the assessment process (e.g., common reactions, feelings, emotions).
- Several screening tools are referred to regularly throughout modules 4A through 4C including:
  - Addiction Severity Index (ASI) (McLellan et al. 1992)
  - ASAM PPC-2R (ASAM 2001)
  - Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 1992)
  - CAGE (Mayfield et al. 1974)
  - Dartmouth Assessment of Lifestyle Inventory (DALI) (Rosenberg et al. 1998)
  - Drug Abuse Screening Test (DAST) (Skinner 1982)
  - Global Appraisal of Individual Needs (GAIN) (Dennis 1998)
  - LOCUS (American Association of Community Psychiatrists [AACP] 2000*a*)
  - Mental Health Screening Form-III (MHSF-III) (Carroll and McGinley 2001)
  - Michigan Alcoholism Screen Test (MAST) (Selzer 1971)
  - Simple Screening Instrument for Substance Abuse (SSI-SA) (CSAT 1994*c*)
- For brevity purposes, the full citations for these screening tools are provided here but are omitted from the remainder of the modules.

Seating

- Participants will be working with partners for much of this module. If the trainer prefers that participants work with someone other than the person they initially sit with, pair participants quickly before the training begins. This can be done as a brief warm-up activity or by having half of the participants pick a name from a bag as they walk in.

Option for Advanced Participant Groups

- For participants who are proficient in screening and assessment and for whom the script as written would provide no significant new learning, Modules 4A, 4B and 4C provide an opportunity to examine the screening and assessment processes in their program and compare these to the guidance and recommendations in Chapter 4 of the TIP. Participants can then suggest how performance might be improved in these areas.
- The Option for Advanced Participant Groups begins on page 23 of the training curriculum.

Suggested Timetable for Module 4A	
Introduction ■ Reconvening and Discussion of Self-Assessment in Module 3 ■ Overview of TIP Chapter 4—Assessment ■ Introduction to Modules 4A, 4B and 4C	10 minutes
Screening for COD—Definition and Purpose	2 minutes
TIP Exercise—Screening Instruments ■ Option 1: Behavioral Rehearsal and Discussion—*15 minutes* ■ Option 2: Review and Discussion—*15 minutes*	15 minutes
Screening for COD *(continued)* ■ Introduction to Cases	5 minutes
The 12 Step Assessment Process ■ Step 1: Engage the Client ■ Step 2: Identify and Contact Collaterals (family, friends, and other providers) to Gather Additional Information	10 minutes
Wrap up	3 minutes
TOTAL	**45 minutes**

10 minutes

OH #4A-1

Introduction

Reconvening and Discussion of Self-Assessment in Module 3

Trainer Note:

- Module 4A requires participants to immediately access their text, so the facilitator will need to make sure all participants have a copy available. Lend copies or have people share if they forgot their TIP.
- The module opens with a trainer-led large group discussion that serves both to recall Module 3 content and the participants' perspectives regarding the process of screening and assessment, which are the focus of Module 4A. This initial discussion lays the groundwork for integration of the module's subsequent content and requires that the trainer be thoroughly familiar with the module and Chapter 4 in the TIP.

- We concluded Module 3 with some self-assessment activities. These involved assessment of your attitudes and values (page 57), your competencies (page 58 or page 60) and strategies to avoid burnout (page 62). Look back over your responses for a moment.

Discussion Questions

- ***ASK***—What was that process like for you, how did it feel? What surprised you? Did you feel the results gave an accurate representation of you? *(Elicit a few responses. Probe for specifics.)*
- ***ASK***—What would have been different if you knew the results were going into your permanent file? That your future might be decided based on the results? *(Elicit a few responses. Probe for thoughtful reactions.)*
- ***ASK***—How might it affect the results if your conversational skills were good but your reading ability was at a 2nd or 3rd grade level? Or what if you had a learning disability? Would this have been readily apparent to me? Why might you not want to tell me you couldn't read well? *(Elicit a few responses. Probe for thoughtful reactions.)*
- ***ASK***—What if English were not your native language and although your oral language was adequate, the terminology or structure of written English was confusing? What if the connotation of words was different because of cultural differences, how might that affect the results? *(Elicit a few responses. Probe for thoughtful reactions.)*
- ***ASK***—What if I had asked you the questions in an interview style? And what if it were the first time we'd met? How might that affect the process? *(Elicit a few responses. Probe for thoughtful reactions.)*
- As we move through our sessions on assessment, keep these comments and reactions in mind.

Overview of TIP Chapter 4—Assessment

Trainer Note:

- This section introduces the chapter's main topic of assessment and explains the three-module (ABC) design.
- Ask participants to open their TIP 42 to the "In This Chapter" text box on page 65.

- Chapter 4 in TIP 42 addresses the assessment process.
- The first part of the chapter, starting on page 66, describes the basic screening and minimal assessment of COD that is necessary for initial treatment planning.
- It is the intent of this chapter, however, to present an approach for a comprehensive assessment of clients with COD and to encourage the field to move toward this ideal. A comprehensive assessment as described in this chapter leads to improved treatment planning and treatment matching.
- Our focus then will be on this exemplary assessment process, a 12 step process that begins on page 71. Of course, we always have to keep in mind that it is a goal and that program constraints may require a compromise between the basic and the ideal.

Introduction to Modules 4A, 4B and 4C

OH #4A-2

- Review of this chapter of the TIP will be carried out as a cluster of three (3) modules that build upon each other. In general:
  - Module 4A will cover the introductory terminology and Steps 1 and 2 of the assessment process.
  - Module 4B will examine Step 3 through Step 7 of the assessment process.
  - Module 4C will conclude the assessment process with Step 8 through Step 12.
  - Included in these Modules will be work on case studies, review of relevant appendices in your TIP text, and key considerations in treatment matching.

2 minutes

Screening for COD-Definition and Purpose

Trainer Note:

- After briefly defining the screening process, the module presents two (2) options for dyads to explore and discuss the process by reviewing or implementing screening instruments available in the TIP's appendices.
- If the trainer is unfamiliar with participants' practical experience conducting screening and assessments:
  - *Ask* for a show of hands regarding how many have conducted screenings? Assessments?
  - *Ask* what they were screening or assessing for and the name of instruments used.
- The names of any instruments used should be solicited, particularly experience with the Mental Health Screening Form-III (MHSF-III) and the Simple Screening Instrument for Substance Abuse (SSI-SA). This information allows the trainer to match the audience's needs with Discussion Option 1 or Discussion Option 2 in the *TIP Exercise* below.

- Screening and assessment are terms that are often linked, but they are separate procedures. *Screening is a formal process of testing to determine whether a client does or does not warrant further attention in regard to a particular disorder.* Essentially it provides the answer to a "yes" or "no" question.

OH #4A-3

- The screening process for COD also seeks to answer a "yes" or "no" question:
  - Does the substance abuse client being screened show signs of a possible mental health problem?

    OR

  - Does the mental health client being screened show signs of a possible substance abuse problem?

15 minutes

TIP Exercise—Screening Instruments

Trainer Note:

- Two (2) options are provided depending on participants' familiarity with the MHSF-III or the SSI-SA.
- Because of time constraints, the facilitator will need to manage the time for these activity/discussions with authority and deliver instructions clearly. This requires familiarity with the script and the TIP. A kitchen timer is also useful.

Option 1: Behavioral Rehearsal and Discussion

Trainer Note:

- This option should be used if participants do not have experience administering either the MHSF-III or the SSI-SA. The MHSF-III may be of particular interest to substance abuse treatment professionals, and the SSI-SA to mental health professionals.
  - The trainer guides participants through a very brief introduction of the instruments in Appendix H (the MHSF-III and the SSI-SA).
  - Then participants have ten (10) minutes to take turns administering the instrument they are least familiar with or most interested in.
  - The goal of Option 1 is not to teach screening protocols but simply to familiarize participants with the instruments and the process, and to provide a common experience.
  - Additional information and references are available in the chapter and Appendix H, and participants are encouraged to read further.
  - Finally, the trainer leads a two (2)-minute debriefing asking for quick reactions from the "clinician" or "client" perspective before resuming the presentation on screening.

- The TIP text provides examples of instruments used to screen for mental health or for substance abuse. Please turn to page 497, which begins Appendix H in your text. *(Allow participants to access page 497.)*
- Both of these instruments are available for unrestricted use and both require minimal staff training for use. Their simplicity makes incorporating them into treatment services relatively easy.

Mental Health Screening Form-III (MHSF-III)

- The first instrument is the Mental Health Screening Form-III on page 500. Please turn to page 500. *(Wait until all have accessed page 500.)*
- The Mental Health Screening Form-III or MHSF-III was initially designed for clients seeking admission to substance abuse treatment programs as a rough screening device for mental health issues.
- Because all questions reflect the respondent's life history, they all start with "Have you ever . . .?" Notice that all questions have a Yes or No answer.
  - Once the client has answered "yes or no" to all the interviewer's questions, the interviewer or another qualified health professional will return to any question with a "yes" answer and probe further.
  - Examples of the probe questions are listed in your text on page 498 under Guidelines for Using the MHSF-III.
- The MHSF-III features a "Total Score" line to reflect the total number of "yes" responses. The maximum score is 18. A "yes" response to any of questions 5-17 raises the possibility of a current mental health problem. Each question reflects symptoms associated with a particular diagnosis.
  - Question 5, for example, would be associated with schizophrenia.
  - Question 6 with depressive disorders, and so on.

Simple Screening Instrument for Substance Abuse (SSI-SA)

- The second screening instrument we are going to examine is the Simple Screening Instrument for Substance Abuse or SSI-SA. A copy of the interview version is on page 506. Please turn to page 506. *(Wait for participants to access page 506.)*

- The SSI-SA was developed by the consensus panel responsible for TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases*.
- The SSI-SA is a 16-item scale, although only 14 items are scored. Scores can range from 0 to 14. These 14 items were selected by the TIP 11 consensus panelists from existing alcohol and drug abuse screening tools.
- A score of 4 or greater has become the established cut-off point for warranting a referral for a full assessment. More information on scoring and the instrument's reliability and validity are discussed starting on page 499.

(Show Slide 4A.4 only for Option 1.)

OH #4A-4

- With your partner, I would like you to take turns administering whichever screening tool you are least familiar with. We will not be following correct protocol; this is simply meant to familiarize you with the instrument.
  - You can answer from the perspective of a client you are familiar with, or you can turn to pages 69 and 70 and take on the persona of one of the case studies there.
  - When you are in the role of the clinician, pay attention to what it feels like to ask the questions.
  - When you are in the role of the client, pay attention to what it feels like to answer the questions.
- You will have ten (10) minutes to complete this exercise. I will let you know when you reach the 5-minute mark so you and your partner can switch roles.

Trainer Note:

- Set timer for five (5) minutes. Call time and have partners switch roles.
- Set timer for another five (5) minutes. Call time to end the exercise. In the large group, ask participants for their reactions.
- Keep this feedback brief; spend no more than two (2) minutes gathering reactions.

- ***ASK***—for quick reactions from "clinician" and "client" perspectives.
  - What was it like to be in the clinician's role?
  - What was it like to be in the client's role?

Trainer Note:

- Encourage participants to read Appendix H to learn more about the instruments.
- Resume lecture on screening below.

Option 2: Review and Discussion

Trainer Note:

- This option should be used if participants have experience administering both the MHSF-III AND the SSI-SA.
  - The trainer refers participants to Appendix H (the MHSF-III and the SSI-SA) and to Appendix G, which have brief descriptions of several screening and assessment instruments.
  - Dyads spend ten (10) minutes reviewing descriptions of the instruments, exchanging information regarding the attributes of instruments they have used, and making recommendations.
  - Participants briefly report out (5 minutes) before the trainer resumes the lecture on screening.

(Show Slide 4A.5 only for Option 2.)

OH #4A-5

- Please turn to page 497, which is Appendix H in your text. Two (2) screening instruments, the Mental Health Screening Form-III and the Simple Screening Instrument for Substance Abuse (SSI-SA) have been provided on page 500 and on page 506. *(Allow participants to access and flip through pages 497 through 506.)*
- Then starting on page 487, Appendix G provides brief descriptions of several additional screening and assessment Instruments. You may have experience with some of these as well.

- With your partner, I would like you to spend the next ten (10) minutes discussing the instruments you have used among those found in Appendix G.
  - What, in your experience, are some of the advantages and disadvantages of each instrument?
  - Which one would you recommend and why?

Trainer Note:

- Set timer for ten (10) minutes. Call time.
- Have dyads report out; spend no more than five (5) minutes gathering responses. Probe, if needed, for reasons and recommendations.
- Resume lecture on screening below.

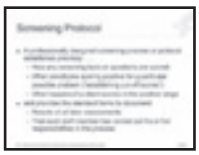
5 minutes

Screening for COD—continued

Trainer Note:

- The brief lecture on the screening process continues, including review of the essential elements of a screening protocol and brief review of how closely the screening protocols used by participants in their programs match those discussed in the TIP. Screening is then briefly linked to assessment and to treatment planning.

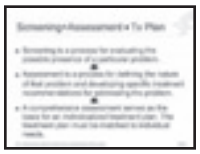
- As stated earlier, the function of the screening process is ***not*** to identify what kind of problem the person might have or how serious it might be. Screening simply determines whether or not the person has a disorder to indicate that further assessment is warranted. Essentially it provides the answer to a "yes" or "no" question.
- If further assessment is warranted, it should be clear from the program's screening protocol or procedure what steps will be taken to ensure that the client is assessed.



OH #4A-6

- A professionally designed screening process or protocol establishes *precisely*:
  - How any screening tools or questions are to be scored
  - What constitutes scoring positive for a particular possible problem (often called "establishing cut-off scores")
  - What takes place after a client scores in the positive range
  - The necessary standard forms to be used to document: 1) the results of all later assessments, and 2) that each staff member has carried out his or her responsibilities in the process
- ***ASK***—If an inspection of the screening protocol at your program took place today and staff were asked to explain it:
  - Would most staff be familiar with the components of the protocol?
  - Would everyone's answers be consistent?
  - Would existing documentation be consistent with the documentation that is called for in the protocol?
  - Or, if your program has a screening protocol, is everyone following it?

Screening + Assessment → Treatment Plan



OH #4A-7

- Screening is a process for evaluating the possible presence of a particular problem.
- Assessment is a process for defining the nature of that problem and developing specific treatment recommendations for addressing the problem.
- A comprehensive assessment serves as the basis for an individualized treatment plan. The treatment plan must be matched to individual needs according to multiple considerations.
  - There is no single, correct intervention or program for individuals with COD.

Introduction to Cases

Trainer Note:

- If time is short, the trainer can delete this section without disrupting the module's flow. This section briefly illustrates the concept of integrated treatment by examining one of the cases that will be used throughout Modules 4A-4C.

- On pages 69 and 70, the TIP provides three (3) cases that illustrate how a comprehensive assessment process helps to generate an integrated treatment plan appropriate to the needs of an individual client.
  - During our sessions on assessment, we will be working with these three (3) cases of Maria, George, and Jane. Right now, we will only examine Maria's case. *(Have participants turn to page 69. Trainer can read or have a participant read as others follow along in their book.)*

Case 1: Maria M.

The client is a 38-year-old Hispanic/Latina woman who is the mother of two teenagers. Maria M. presents with an 11-year history of cocaine dependence, a 2-year history of opioid dependence, and a history of trauma related to a longstanding abusive relationship (now over for 6 years). She is not in an intimate relationship at present and there is no current indication that she is at risk for either violence or self-harm. She also has persistent major depression and panic treated with antidepressants. She is very motivated to receive treatment.

- ***ASK***—What would you recommend for Maria?
- The TIP Consensus Panel has recommended an integrated treatment plan that might include:
- Medication-assisted treatment (e.g., methadone or buprenorphine), continued antidepressant medication, 12-Step program attendance, and other recovery group support for cocaine dependence.
- Referral to a group for trauma survivors that is designed specifically to help reduce symptoms of trauma and resolve long-term issues.
- Individual, group, and family interventions could be coordinated by the primary counselor from opioid maintenance treatment.
  - The focus of these interventions might be on relapse prevention skills, taking medication as prescribed, and identifying and managing trauma-related symptoms without using.
- An appropriate long-term goal would be to establish abstinence and engage Maria in longer-term psychotherapeutic interventions to reduce trauma symptoms and help resolve trauma issues.
  - If a local mental health center had a psychiatrist trained and licensed to provide Suboxone (the combination of buprenorphine and nalaxone), her case could be based in the mental health center.
- ***ASK***—Does this plan address all Maria's areas of need?

10 minutes

The 12 Step Assessment Process

Trainer Note:

- This next section introduces the major goals of the assessment model. Step 1 and Step 2 are covered in this module.

- Please turn to page 71. This section introduces the 12 steps in the assessment process. *(Allow participants to access page 71.)*
- The purpose of the assessment process is to develop a method for gathering information in an organized manner that allows the clinician to develop an appropriate treatment plan or recommendation.
- The 12 step assessment process described in this chapter and in the rest of our sessions will discuss how this assessment process might occur, and how the information gathered leads to a rational process of treatment planning.
  - We will also apply some of the steps to the case studies of Maria, George and Jane.
- The major aims of the assessment process are listed on the left-hand column of page 71:
  - To obtain a more detailed chronological *history* of past mental symptoms, diagnosis, treatment, and impairment, particularly before the onset of substance abuse, and during periods of extended abstinence.
  - To obtain a more detailed description of *current* strengths, supports, limitations, skill deficits, and cultural barriers related to following the recommended treatment regimen for any disorder or problem.
  - To determine *stage of change for each problem*, and identify external contingencies that might help to promote treatment adherence.
- On page 72, in the text box at the bottom of the page are the 12 Steps in the Assessment process. *(Allow participants to access page 72.)*

Step 1: Engage the Client

Trainer Note:

- Recalls the discussion and experience from the *TIP Exercise* on screening instruments that began the module to emphasize the importance of client engagement.
- Reviews the five (5) key concepts that underlie effective engagement during the initial contact:
  - "No wrong door"
  - Empathic detachment
  - Person-centered assessment
  - Sensitivity to culture, gender, and sexual orientation
  - Trauma sensitivity

- The first step is to "engage the client."
- ***ASK***—Thinking back to our discussion at the beginning of this session regarding your assessment experience, why would client engagement be a crucial step? *(Elicit participant comments. If not mentioned by the participants, include:)*
  - Engaging the client in an empathic, welcoming manner builds rapport and facilitates disclosure of information regarding mental health problems, substance use disorders, and related issues.
  - The aim is to create a safe and nonjudgmental environment in which sensitive personal issues may be discussed.
  - Cultural issues, including the use of the client's preferred language, play a role in creating a sense of safety and promote accurate understanding of the client's situation and options.

OH #4A-8

- The consensus panel identified five (5) key concepts that underlie effective engagement during the initial clinical contact:

Universal access—No wrong door

- "No wrong door" refers to formal recognition that individuals with COD may enter a range of community service sites and that proactive efforts are necessary to welcome them into treatment and prevent them from falling through the cracks.
  - The recommended attitude is: *The purpose of this assessment is not just to determine whether the client fits in my program, but to help the client figure out where he or she fits in the system of care, and to help him or her get there.*

Empathic detachment

- Empathic detachment requires the assessing clinician to acknowledge that the clinician and client are working together to make decisions to support the client's best interest.
  - This involves recognition that the clinician cannot transform the client into a different person, but can only support change that the client is already making.
  - Even if the client does not seem to fit into the clinician's expectations, treatment categories, or preferred methods of working, maintaining an empathic connection is essential for the client to remain engaged.
- Clinicians should be prepared to respond to the requirements of clients with COD.
  - Counselors should be careful not to label mental health symptoms immediately as caused by addiction, but be comfortable with the strong possibility that a mental health condition may be present independently.
  - They should also encourage disclosure of information that will help clarify the meaning of any COD for that client.

Person-centered assessment

- Person-centered assessment emphasizes that the focus of initial contact is *not* on filling out a form or answering several questions or on establishing program fit.
- Rather, the focus of initial contact is on finding out what the client wants, in terms of his or her perception of the problem, what he or she wants to change, and how he or she thinks that change will occur.

Sensitivity to culture, gender, and sexual orientation

- Culture plays a significant role in determining the client's view of the problem and the treatment.
  - Ethnic cultures may differ significantly in their approach to substance use disorders and mental disorders, and this may affect how the client presents.
  - Clients may participate in treatment cultures (12-Step recovery, Dual Recovery Self-Help, psychiatric rehabilitation) that also may affect how they view treatment.
- Cultural sensitivity also requires recognition of one's own cultural perspective and a genuine spirit of inquiry into how cultural factors influence the client's request for help.
- During the assessment process, it is important to ascertain the individual's sexual orientation as part of the counselor's appreciation for the client's personal identity, living situation, and relationships.

Trauma sensitivity

- The high prevalence of trauma in individuals with COD requires that the clinician consider the possibility of a trauma history even before the assessment begins.
  - This pre-interview consideration means that the approach to the client must be sensitive to the possibility that the client has suffered previous traumatic experiences that may interfere with his or her ability to be trusting of the counselor.
  - Trauma may include early childhood physical, sexual, or emotional abuse; experiences of rape or interpersonal violence as an adult; and traumatic experiences associated with political oppression, as might be the case in refugee or other immigrant populations.
  - Clinicians who observe guardedness on the part of the client should consider the possibility of trauma and try to promote safety in the interview through providing support and gentleness, rather than trying to "break through" evasiveness that erroneously might look like resistance or denial.
  - All questioning should avoid "retraumatizing" the client.

Step 2: Identify and Contact Collaterals (family, friends, and other providers) to Gather Additional Information

Trainer Note:

- Emphasizes the importance of obtaining information from collateral sources throughout the assessment process.

- Clients may be unable or unwilling to report past or present circumstances accurately. It is recommended that all assessments include routine procedures for identifying and contacting any family and other collaterals who may have useful information.
  - The process of seeking such information must be carried out strictly in accordance with applicable guidelines and laws regarding confidentiality and with the client's permission. (See footnote at the bottom of page 75 for regulations governing confidentiality.)
- Although gathering collateral information has been designated as Step 2, information from collaterals is valuable as a supplement to the client's own report in *all of the assessment steps* we will discuss.

Steps in the assessment process are not always sequential and may occur in different order.

Trainer Note:

- Close the presentation with a reminder that although the steps appear sequential, they could occur simultaneously or in a different order depending on the situation.

- Presenting the steps in sequence is a convenient format that makes it easier to discuss and remember them. However, some steps could occur simultaneously, such as engaging the client, which should occur throughout the process. Some may occur in a different order, depending on the situation.
  - For example, it is particularly important to identify and attend to any acute safety needs, which often have to be addressed before a more comprehensive assessment process can occur.
- Finally, assessment is an ongoing process. It does not start with Step 1 and end with Step 12.
  - While the assessment seeks to identify individual needs and vulnerabilities as quickly as possible to initiate appropriate treatment, as treatment proceeds and as other changes occur in the client's life and mental status, counselors must actively seek current information rather than proceed on assumptions that might be no longer valid.

3 minutes

Wrap up

Trainer Note:

- Encourage participants to review the text box on page 67-Advice to the Counselor: Do's and Don'ts of Assessment for COD.
- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

MODULE 4A
Option for Advanced Participant Groups

Trainer Note:

- For participants who are proficient in screening and assessment and for whom the script as written would provide no significant new learning, Modules 4A, 4B and 4C provide an opportunity to examine the screening and assessment processes in their program and compare these to the guidance and recommendations in Chapter 4 of the TIP. Participants can then suggest how performance might be improved in these areas.
- Participants should be encouraged to interact continuously with the TIP text during the session as it contains information useful at many levels of proficiency.

Use of Program Documentation

- If the trainer is part of the program staff, such as the clinical supervisor, randomly selected charts or program documentation could be reviewed and discussed by the participants. Discussion could include how well the participants' initial perceptions regarding program performance were supported by the documentation.

Group Assignments

- Depending on the needs of the program and the number of participants:
  - Small groups each can be assigned a different step as their focus during the entire session, or
  - Small groups each can be assigned subtopics within the different steps as that step becomes the focus of the session.

Suggested Timetable for Module 4A—Advanced	
Introduction ■ Reconvening and Discussion of Self-Assessment in Module 3 ■ Overview of TIP Chapter 4—Assessment ■ Introduction to Modules 4A, 4B and 4C	10 minutes
Screening for COD	32 minutes
Wrap up	3 minutes
TOTAL	**45 minutes**

10 minutes

Introduction

Trainer Note:

- The Introduction for the advanced option follows the same format as for the non-advanced training.
- ***Follow the training format beginning on page 4.***

- Reconvening and Discussion of Self-Assessment in Module 3
- Overview of TIP Chapter 4—Assessment
- Introduction to Modules 4A, 4B and 4C

32 minutes

Screening for COD

Trainer Note:

- For the advanced option, substitute the following material for the sections on Screening for COD, TIP Exercise-Screening Instruments, and The 12 Step Assessment Process in the non-advanced version of the curriculum.
- The trainer will need to determine how much time to allot to each discussion activity.
- The names of any instruments used should be solicited, particularly experience with the Mental Health Screening Form-III (MHSF-III) and the Simple Screening Instrument for Substance Abuse (SSI-SA).
- Also, the trainer may want to refer participants to Appendix H (the MHSF-III and the SSI-SA) and to Appendix G, which have brief descriptions of several screening and assessment instruments.

- Ask participants to review the guidance on page 66 and then discuss how closely screenings routinely carried out in their program comply with the recommendations.

- Possible questions and probes the trainer can use for large or small group discussions include:
  - How is the screening tool used in your program scored? What is the protocol for determining which clients screen positive?
    - Do all participants agree?
    - Is this consistent with the instrument's guidelines?
  - In day-to-day practice, what typically takes place after a client scores in the positive range?
    - Do all participants agree?
    - Is this consistent with your program guidelines?

– What is the protocol for documentation of the screening process?

  • Would documentation examined today demonstrate consistent implementation of the protocol by all staff?

– How can your program's screening process be improved?

Step 1: Engage the Client

Trainer Note:

■ Depending on the needs of the program and the number of participants, form small groups of 3-5 people.

  – Small groups each can be assigned a different step as their focus during the entire session, or

  – Small groups each can be assigned subtopics within the different steps as that step becomes the focus of the session.

■ Participants briefly review Step 1 on page 72. Discussion can then address how well their program implements the five (5) key concepts and what could be improved in the area of:

1. Universal access ("No wrong door")
2. Empathic detachment
3. Person-centered assessment
4. Sensitivity to culture, gender, and sexual orientation
5. Trauma sensitivity

Step 2: Identify and Contact Collaterals (family, friends, and other providers) to Gather Additional Information

■ Participants briefly review Step 2 on page 74. Discussion can then center on:

  – How effectively is information gathered from collateral sources?

  – What are practical suggestions that could improve this process?

3 minutes

Wrap up

Trainer Note:

- Follow the same format as for the non-advanced training. See pages 21-22.

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 4A

Introduction

Assessment:
Screening and Step 1 & Step 2

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

TIP Chapter 4: Assessment

- **Module 4A**
  - Introduction, terminology, Step 1–Step 2
- Module 4B
  - The Assessment Process: Step 3–Step 7
- Module 4C
  - The Assessment Process: Step 8–Step 12
- Case studies, review of relevant appendices, and key considerations in treatment matching.

Screening

- Screening for COD seeks to answer a “yes” or “no” question:
  - Does the substance abuse client being screened show signs of a possible mental health problem?

OR

  - Does the mental health client being screened show signs of a possible substance abuse problem?

TIP Exercise—
Screening Instruments

Option 1: Behavioral Rehearsal & Discussion
With your partner, take turns administering whichever instrument is least familiar:

- Mental Health Screening Form-III (p. 500)
- Simple Screening Instrument for Substance Abuse (p. 506)

You have 10 minutes total!

TIP Exercise—
Screening Instruments

Option 2: Review & Discussion

Review instruments in:

- Appendix H (p. 497) and Appendix G (p. 487).

Discuss with your partner:

- Which instruments have you used?
- What, in your experience, are advantages and disadvantages of each?
- Which would you recommend? Why?

You have 10 minutes total!

Screening Protocol

- A professionally designed screening process or protocol establishes *precisely . . .*
  - How any screening tools or questions are scored
  - What constitutes scoring positive for a particular possible problem (“establishing cut-off scores”)
  - What happens if a client scores in the positive range
- and provides the standard forms to document
  - Results of all later assessments
  - That each staff member has carried out his or her responsibilities in the process

Screening+Assessment ➪ Tx Plan

- Screening is a process for evaluating the possible presence of a particular problem.

- Assessment is a process for defining the nature of that problem and developing specific treatment recommendations for addressing the problem.

- A comprehensive assessment serves as the basis for an *individualized* treatment plan. The treatment plan must be matched to individual needs.

Step 1: Engage the Client

- “No wrong door”
- Empathic detachment
- Person-centered assessment
- Sensitivity to culture, gender, and sexual orientation
- Trauma sensitivity

MODULE 4B: Assessment: Step 3—Step 7

Objectives

- Chapter 4 in the TIP presents an approach to comprehensive assessment of clients with COD and has as its purpose to encourage the field to move toward this ideal. In order to adequately address the chapter's main topics of screening and assessment, Module 4 has been designed as a cluster of three (3) 45-minute sessions that build on one another: Module 4A, Module 4B and Module 4C.
  - *Module 4A* addressed screening and Step 1 and Step 2 of the assessment process.
  - ***Module 4B* examines:**

    Step 3: Screen for and Detect Co-Occurring Disorders

    Step 4: Determine Quadrant and Locus of Responsibility

    Step 5: Determine Level of Care

    Step 6: Determine Diagnosis

    Step 7: Determine Disability and Functional Impairment

    Case studies and review of relevant appendices in the TIP text
  - *Module 4C* examines Step 8 through Step 12 of the assessment process.

Trainer Note:

- The following sections refer to Module 4B only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Copies of the TIP ZIP test, one per participant *(See Handout section for master copy.)*
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 4B.1—4B.18
- Kitchen timer
- Markers and Post-It Notes for participants to use on their TIP texts
- Small reward such as candy, markers or other extrinsic reward for TIP ZIP test winners

Module Design

- This module continues the three-module presentation of the TIP's 12 Step assessment process. Module 4B is a blend of discussion, lecture, activity, and interaction with the TIP text. As in the previous module, discussions are either trainer-led or occur in participant dyads. Some TIP Exercises are trainer-led and built into the flow of the lecture. These do not have associated slides.
- Several screening tools are referred to regularly throughout modules 4A through 4C including:
  - Addiction Severity Index (ASI) (McLellan et al. 1992)
  - ASAM PPC-2R (ASAM 2001)
  - Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 1992)
  - CAGE (Mayfield et al. 1974)
  - Dartmouth Assessment of Lifestyle Inventory (DALI) (Rosenberg et al. 1998)
  - Drug Abuse Screening Test (DAST) (Skinner 1982)
  - Global Appraisal of Individual Needs (GAIN) (Dennis 1998)
  - LOCUS (American Association of Community Psychiatrists [AACP] 2000*a*)
  - Mental Health Screening Form-III (MHSF-III) (Carroll and McGinley 2001)
  - Michigan Alcoholism Screen Test (MAST) (Selzer 1971)
  - Simple Screening Instrument for Substance Abuse (SSI-SA) (CSAT 1994*c*)
- For brevity purposes, the full citations for these screening tools are provided here but are omitted from the remainder of the modules.

Seating

- Participants will briefly work with partners on some of the exercises. If the trainer prefers that participants work with someone other than the person they initially sit with, pair participants quickly before the training begins. This can be done as a brief warm-up activity of by having half of the participants pick a name from a bag as they walk in.

Option for Advanced Participant Groups

- For participants who are proficient in screening and assessment and for whom the script as written would provide no significant new learning, Modules 4A, 4B and 4C provide an opportunity to examine the screening and assessment processes in their program and compare these to the guidance and recommendations in Chapter 4 of the TIP. Participants can then suggest how performance might be improved in these areas.
- The Option for Advanced Participant Groups begins on page 32 of the training curriculum.

Suggested Timetable for Module 4B

Introduction ■ Reconvening and Review of Module 4A	5 minutes
TIP ZIP Test	5 minutes
Step 3: Screen for and Detect Co-Occurring Disorders ■ Introduction ■ Safety Screening ■ Quick TIP Exercise—*Optional: 1-2 minutes* ■ Screening for Past and Present Mental Disorders ■ Screening for Past and Present Substance Use Disorders ■ Trauma Screening	10 minutes
Step 4: Determine Quadrant and Locus of Responsibility ■ Determination of SMI Status ■ Determination of Severity of Substance Use Disorders ■ Application to Case Examples ■ TIP Exercise—Cases and Quadrants of Care—*3 minutes*	5 minutes
Step 5: Determine Level of Care	2 minutes
Step 6: Determine Diagnosis ■ Importance of Client History ■ TIP Exercise—Application to Case Examples ■ Documenting Prior Diagnosis ■ Linking Mental Symptoms to Specific Periods	10 minutes
Step 7: Determine Disability and Functional Impairment ■ Introduction ■ TIP Exercise—Application to Case Examples—*3 minutes* ■ Assessing Functional Capability ■ Determining Need for “Capable” or “Enhanced” Services	5 minutes
Wrap up ■ TIP ZIP Test Review	3 minutes
TOTAL	**45 minutes**

5 minutes

OH #4B-1

OH #4B-2

Introduction

Reconvening and Review of Module 4A

Trainer Note:

- The reconvening section briefly reviews Module 4A and sets up Module 4B. This should be done quickly and may be unnecessary if little time has elapsed between modules.
- Check that everyone has a copy of the TIP. Lend copies or have people share.

- Our review of Chapter 4 of the TIP text began last session with Module 4A. In that session we discussed the screening process in general and a few screening instruments. We also examined Steps 1 and 2 of the 12 Step assessment process.
- *Optional: If participants include mental health clinicians*—Remember that although the TIP material is directed toward substance abuse treatment clinicians working in substance abuse treatment settings, many of the steps apply equally well to mental health clinicians in mental health settings.
- I would like us to keep the major aims of the assessment process in mind. They are listed in the left-hand column on page 71. *(Allow participants to access page 71.)*
  - To obtain a more detailed chronological *history* of past mental symptoms, diagnosis, treatment, and impairment, particularly before the onset of substance abuse, and during periods of extended abstinence.
  - To obtain a more detailed description of *current* strengths, supports, limitations, skill deficits, and cultural barriers related to following the recommended treatment regimen for any disorder or problem.
  - To determine *stage of change for each problem*, and identify external contingencies that might help to promote treatment adherence.

- The 12 Steps in the Assessment Process recommended by the TIP text are listed on page 72. Please turn to page 72. *(Allow participants to access page 72.)*
- Step 1 urged us to engage the client. Last session we examined five (5) key concepts that underlie effective engagement during the initial clinical contact. We talked about the importance of creating a safe and nonjudgmental environment to facilitate discussion of sensitive personal issues, not only at initial contact, but also throughout the assessment process.
- Step 2 addressed the importance of obtaining collateral information from family, friends and other providers to supplement client information throughout the assessment process.
- In Module 4B today, we will continue examination of the steps and focus on Steps 3, 4, 5, 6 and 7. We will also look at application of these to the case studies in the TIP.
- There is a great deal of information for clinicians in this section of the text that cannot be addressed or addressed in detail because of time constraints. Please read this chapter so that you may take advantage of all the information provided.

5 minutes

TIP ZIP Test

Trainer Note:

- The intention of the TIP ZIP Test is to focus participant attention. Each participant will need a copy of the test. A master copy is included in the Handout section.
- Five (5) minutes are allowed for the test. Use a kitchen timer to enforce time.
- Participants may NOT use the TIP during test taking.
- Small prizes such as candy or markers can be presented at the end of the session for those with the most correct answers.

- To get us started, we are going to take a TIP ZIP test. The questions deal with some of the topics we will cover today. There are no grades, no penalties. It is just a way of focusing on our topic. You will have five (5) minutes to complete the test. Please close your TIP texts and don't peek. During the last two (2) minutes, you can check with your neighbor and change your responses if you wish. But you can't check in the TIP.

Trainer Note:

- Hand out TIP ZIP Test for Module 4B.
- Allow three (3) minutes for testing.
- Allow two (2) minutes for discussion of responses with their neighbors. Participants may change their answers if they wish.
- Resume presentation.

- As we go through the module, you will be able to check your responses and decide what the correct answer is. At the end of the session, we will take a final tally of our responses.

10 minutes

Step 3: Screen for and Detect Co-Occurring Disorders

Trainer Note:

- ***Step 3—Step 7 (General comments)***—Topic sections often begin with the trainer asking participants how this is carried out in their day-to-day practice or programs. The intent is to:
  - Help participants connect the TIP information to their practice.
  - Give the trainer insight into participants' expertise in this area to determine how much detail they will need. This is particularly helpful if the trainer is unfamiliar with participants.
  - Provide segues and concrete examples for the script items.
- The trainer will need to manage time well during this module, as there is a great deal of information and opportunity for interaction. Preparation should include selecting which examples and TIP exercises will be most valuable for the participants should time become a problem, as well as which of the secondary and tertiary level comments should be included and which omitted.

OH #4B-3

OH #4B-4

OH #4B-5

Introduction

- The next step in our assessment process is to screen for co-occurring disorders.
- As we discussed in the last session, the screening process for COD seeks to answer a "yes" or "no" question:
  - Does the substance abuse client being screened show signs of a possible mental health problem?

    OR

  - Does the mental health client being screened show signs of a possible substance abuse problem?
- All individuals presenting for substance abuse treatment should be screened routinely for co-occurring mental disorders. All individuals presenting for treatment for a mental disorder should be screened routinely for any substance use disorder. The reasons are practical ones:
  - There is a high prevalence of co-occurring mental disorders in substance abuse treatment settings
  - Treatment outcomes for individuals with multiple problems improve if each problem is addressed specifically
- In mental health settings, substance abuse screening should:
  - Screen for acute safety risk related to serious intoxication or withdrawal
  - Screen for past and present substance use, substance related problems, and substance-related disorders
  - Screen for past and present victimization and trauma
- In substance abuse treatment settings, mental health screening has four (4) major components:
  - Screen for acute safety risk
    - This includes suicide, violence, inability to care for oneself, HIV and hepatitis C virus risky behaviors, and danger of physical or sexual victimization
  - Screen for past and present mental health symptoms and disorders
  - Screen for cognitive and learning deficits
  - Screen for past and present victimization and trauma

Safety Screening

- ***ASK***—How does your program screen for safety? (i.e., suicide, violence, inability to care for oneself, HIV and hepatitis C virus risky behaviors, danger of physical or sexual victimization). Do you use any screening instruments?

Trainer Note:

- Elicit a few responses and use responses if possible to make the following points:

- Safety screening requires that early in the interview the clinician directly ask the client (and anyone else providing information) if the client has any immediate impulse to engage in violent or self-injurious behavior or is in any immediate danger from others.
  - If the answer is yes, the clinician should obtain more detailed information about the nature and severity of the danger, and any other information relevant to safety.
  - If the client appears to be at some immediate risk, the clinician should arrange for a more in-depth risk assessment by a mental-health-trained clinician, and the client should not be left alone or unsupervised.
- An important point to remember is that alcohol and drug abuse are among the highest predictors of dangerousness to self or others—even without the presence of any co-occurring mental disorder. Also, clinicians should not underestimate the risk of threats to harm self or others just because the client made them while intoxicated.
- A variety of tools are available for safety screening. Some instruments like the ASAM PPC-2R, the ASI, the GAIN, and the LOCUS screen for multiple issues and include safety-screening questions. These are discussed on page 75.
- However, clinicians and programs should use such tools only as a starting point, and then ask more detailed questions to get all relevant information.
- One dimension of LOCUS specifically provides guides for scoring severity of risk of harm to self and others. The ratings include what constitutes minimal risk, low risk, moderate, serious and extreme risk of harm. This is provided in your text on page 77. *(Allow participants to access page 77 and scan momentarily.)*
  - Another resource in your TIP is the section on suicide on pages 214-215 of the main text and starting on page 326 in Appendix D. *(If time allows, have participants turn to this section and scan momentarily.)*

Quick TIP Exercise

Trainer Note:

- This is an optional exercise in which the trainer leads a 1-2 minute exploration of the cases.

Look at *Case 1: Maria M.* on page 69.

- What questions might you ask if Maria M. indicates her ex-partner has recently returned to the city and they are seeing each other as "just friends"?

OR

Look at *Case 2: George T.* on page 70.

- What if George T. was obviously high and furious, and blaming his supervisor for revealing the results of his drug test to the general manager who mandated treatment or discharge?

Screening for Past and Present Mental Disorders

- ***ASK***—How does your program screen for mental disorders? What do you screen for? What screening instruments do you use?

Trainer Note:

- Elicit a few responses. Also, work them, if possible, into the following points:

- Screening for past and present mental disorders has three (3) goals:

  1. To understand a client's history. If the history is positive for a mental disorder, this will alert the counselor and treatment team to the types of symptoms that might reappear.

  2. To identify clients who might have a current mental disorder and need both an assessment to determine the nature of the disorder and an evaluation to plan for its treatment.

  3. For clients with a current COD, to determine the nature of the symptoms that might wax and wane so that the client can monitor the symptoms. Special attention is given to how the symptoms improve or worsen in response to medications, "slips" (i.e., substance use), and treatment interventions.

     - For example, clients often need help recognizing that the treatment goal of avoiding isolation improves their mood—that when they call their sponsor and go to a meeting they break the vicious cycle of depressed mood, seclusion, dwelling on oneself and one's mood, increased depression, greater isolation, and so on.

- A number of instruments are available to counselors for screening, assessment, and treatment planning and are discussed in the TIP text on pages 78-82.

- One of the difficulties when using any of the tools that detect symptoms of mental disorders is that symptoms of mental disorder can be mimicked by substances.

  – For example, hallucinogens may produce symptoms that resemble psychosis, and depression commonly occurs during withdrawal from many substances.

- Without additional information such as the history and chronology of symptoms, it can be difficult to distinguish between a mental disorder and a substance-related disorder.

  – Retesting is often important, particularly to confirm diagnostic conclusions for clients who have used substances.

Screening for Past and Present Substance Use Disorder

Trainer Note:

- This section is optional and is intended primarily for counselors working in mental health service settings. It suggests ways to screen clients for substance use problems.

OH #4B-6

- Screening for substance use problems begins with inquiry about past and present substance use and substance-related problems and disorders. If the client answers yes to having problems and/or a disorder, further assessment is warranted.
- It is important to remember that *if the client acknowledges a past substance problem but states that it is now resolved, assessment is still required.* Careful exploration of what current strategies the individual is using to prevent relapse is warranted and helps ensure that those strategies continue during mental health treatment.
- Screening for the presence of substance abuse symptoms and problems involves four (4) components:
  - *Substance abuse symptom checklists:* These include checklists of common categories of substances, history of associated problems with use, and a history of meeting criteria for substance dependence for that substance.
  - *Substance abuse severity checklists* are used to monitor the severity of a substance use disorder (if present) and to determine the possible presence of dependence.
  - *Formal screening tools that work around denial:* Most common substance abuse screening tools have been used with individuals with COD:
    - CAGE
    - Simple Screening Instrument for Substance Abuse (SSI-SA) which is reproduced in its entirety in Appendix H
    - Michigan Alcoholism Screen Test (MAST)
    - The Drug Abuse Screening Test (DAST)
    - Alcohol Use Disorders Identification Test (AUDIT)
    - Dartmouth Assessment of Lifestyle Inventory (DALI) is used routinely as a screening tool in some research settings working with individuals with serious mental disorders

- *Screening of urine, saliva, or hair samples (toxicology screening):* Given the high prevalence of substance use disorders in patients with mental health problems, the routine use of urine or other screening is indicated for all new mental health clients.
  - Suggested especially in settings where clients are likely to present unreliable information such as in adolescent and/or criminal justice settings.
  - Use of urine screening is highly recommended whenever the clinical presentation does not seem to fit the client's story, or where there appear to be unusual mental status symptoms or changes not explained adequately.
  - Saliva testing may be less intrusive than hair or urine testing in patients who are shy or who are extremely paranoid.

Trauma Screening

- It can be damaging to ask the client to describe traumatic events in detail when screening for a history of trauma or in obtaining a preliminary diagnosis of PTSD. It can retraumatize the client. To screen, it is important to limit questioning to very brief and general questions such as, "Have you ever experienced childhood physical abuse? Sexual abuse? A serious accident? Violence or the threat of it?"
- Please turn to page 408 in Appendix D of your TIP text. *(Allow participants to access Appendix D and scan momentarily.)*
- This section offers detailed information on PTSD including a discussion of screening and assessment for PTSD on page 415. I encourage you to read this at your convenience.
- Now, please turn to page 238 in your TIP text. There is a more brief description of PTSD on pages 238-240 of the main text. Again, I encourage you to read this material at your convenience. *(Allow participants to access pages 238-240 and scan momentarily.)*
- Specific screening tools to identify trauma in treatment populations are also available and discussed on page 82. Please turn back to page 82. *(Allow participants to return to Chapter 4 and scan page 82 momentarily.)*

5 minutes

OH #4B-7

OH #4B-8

OH #4B-9

Step 4: Determine Quadrant and Locus of Responsibility

- In Step 4 of the assessment process, determination is made regarding the appropriate quadrant of care and placement.
- In Module 2, we introduced four (4) Quadrants of Care and looked at this graphic. These quadrants are also in the text box at the bottom of page 82, though the order is shifted so Quadrant III is first. *(Allow participants to access page 82.)*
- Remember, this is merely a strategy to help clinicians conceptualize the treatment system. Assignment to the quadrants is based on the *severity of the mental and substance use disorders* and not on the specific diagnosis.

Determination of Serious Mental Illness (SMI) Status

- Every State mental health system has developed a set of specific criteria for determining who can be considered seriously mentally ill. These criteria are different for every state. This is important because individuals meeting the criteria for SMI are eligible for consideration as mental health priority clients.
- Substance abuse treatment providers should obtain copies of the criteria for their State. They should also become familiar with the specific procedures by which eligibility is established by their States' mental health systems.
  - By determining that clients might be eligible for consideration as a mental health priority, the substance abuse treatment counselor can assist them in accessing a range of services and/or benefits that clients may not know are open to them.
- To determine SMI status start by finding out if the client is already receiving mental health priority services (e.g., Do you have a mental health case manager? Are you a Department of Mental Health client?).
  - If the client already is a mental health client, then he or she will be assigned to Quadrant II or IV. Contact needs to be made with the mental health case manager and a means of collaboration established to promote case management.

- If the client is not already a mental health client, but appears to be eligible (and the client and the family are willing) arrange for referral to determine eligibility.
  - Clients who present in addiction treatment settings who look as if they might be SMI, but have not been so determined, should be considered to belong to Quadrant IV.

Determination of Severity of Substance Use Disorders

OH #4B-10

- ***ASK***—Presence of active or unstable substance dependence or serious substance abuse (e.g., recurrent substance-induced psychosis without meeting other criteria for dependence) would identify the client as being in which quadrant? *(Quadrant III or IV)*
- ***ASK***—Less serious substance use disorder (mild to moderate substance abuse; substance dependence in full or partial remission) identifies the client as being in which quadrant? *(Quadrant I or II)*
- Clients in Quadrant III who present in substance abuse treatment settings are often best managed by receiving care in the addiction treatment setting, with collaborative or consultative support from mental health providers.
- Clients in Quadrant IV usually require intensive intervention to stabilize and determine of eligibility for mental health services and appropriate locus of continuing care.
  - If they do not meet criteria for SMI, once their more serious mental symptoms have stabilized and substance use is controlled initially, they begin to look like clients in Quadrant III, and can respond to similar services.

Application to Case Examples

- Please turn back to the cases of Maria M., George T. and Jane B. on page 69 and page 70. Take a moment to review at least one (1) of the cases and think about which quadrant you would assign.

Trainer Note:

- Allow one (1) minute or quickly read the cases aloud.

- On page 83, the TIP has already assigned these cases to quadrants. This is in the text box at the top of the page. Let's see if you agreed with their assignments. *(Wait until participants have accessed page 83.)*
- Both Maria M. and George T. have been assigned to Quadrant III. While they have serious addiction and serious mental disorders, they do not appear to be seriously disabled.
- Jane B. also has serious addiction and serious mental illness. She, however, does appear to be seriously disabled by her condition and would meet the criteria for serious and persistent mental illness in most states. She has been assigned to Quadrant IV.
- ***ASK***—Did anyone assign the cases to a different quadrant?

Trainer Note:

- Probe for reasons and help clarify process for participants if necessary.

TIP Exercise—Cases and Quadrants of Care

- What if things were just a little different? For the next minute, I would like you and your partner to select one (1) of the cases and change it just enough so that the quadrant would need to change. Be ready to give your reasons.

OH #4B-11

Trainer Note:

- Allow participants one (1) minute to select one (1) of the cases and change it just enough so that the quadrant would need to change.
- Call time.
- Allow two (2) minutes for report out.
- Elicit a response for each of the cases. Probe for reasons and correct if necessary.

2 minutes

OH #4B-12

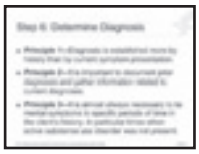
OH #4B-13

Step 5: Determine Level of Care

- In Module 2, we briefly talked about levels of care. Professionals in both mental health and in substance abuse treatment use scales and criteria to help guide client services and determine appropriate placement in "level of care." Discussion of some of the most commonly used scales begins on page 84. *(Allow participants to access page 84.)*
- The American Society of Addiction Medicine's (ASAM) Patient Placement Criteria is one such scale (ASAM 2001). The ASAM Patient Placement Criteria are used to guide addiction treatment matching in more than half the States, and are influential in almost all of the rest.
- In some systems, the LOCUS Adult Version 2000 (AACP 2000*a*) is being introduced as a systemwide level of care assessment instrument for either mental health settings only, or for both mental health and substance abuse treatment settings.
- More detailed explanations, references and websites are available in your TIP on pages 84 and 85.

10 minutes

OH #4B-14



OH #4B-15

Step 6: Determine Diagnosis

- Step 6 often includes dealing with confusing diagnostic presentations. Determining the diagnosis when confronted with the mixed presentation of mental symptoms and ongoing substance abuse in the assessment of COD can be a formidable clinical challenge.
  - As mentioned before, one of the ways addiction counselors can improve their competencies to address COD is to become familiar with the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision* (DSM-IV-TR) (American Psychiatric Association 2000). This is the basic resource used to diagnose mental disorders.
  - Another great resource is in your TIP Chapter 8 and Appendix D, which both provide overviews of Specific Mental Disorders.
- The TIP provides three (3) principles related to determining a diagnosis:
  1. Importance of client history
  2. Documenting prior diagnosis
  3. Linking mental symptoms to specific time periods

Importance of Client History

- ***Principle #1:*** Diagnosis is established more by history than by current symptom presentation. This applies to both mental and substance use disorders.

TIP Exercise—Application to Case Examples

- Please look at the text box at the bottom of page 86.

Trainer Note:

- Read from the following text or allow participants to read.

Case 2

George T. has cocaine dependence and bipolar disorder stabilized with lithium. He reports that when he uses cocaine he has mood swings, but that these go away when he stops using for a while, as long as he takes his medication. At the initial visit George T. states he has not used for a week and has been taking his medication regularly. He displays no significant symptoms of mania or depression and appears reasonably calm. The counselor should not conclude that because George T. has no current symptoms the diagnosis of bipolar disorder is incorrect, or that all the mood swings are due to cocaine dependence. At initial contact, the presumption should be that the diagnosis of bipolar disorder is accurate, and lithium needs to be maintained.

- ***ASK***—Why is it prudent for a clinician to assume George's existing diagnosis is accurate?
- ***ASK***—What if you, the clinician, suspect that George's bipolar diagnosis is inaccurate? What action should you take?

Trainer Note:

- Elicit a few responses. Use responses as segues to make the following points:

- The first step in determining the diagnosis is to find out whether the client has an established diagnosis and/or is receiving ongoing treatment for an established disorder. This can be done during intake.
- If a valid history of a mental disorder diagnosis exists at the time of admission to substance abuse treatment, then that diagnosis should be considered valid for initial treatment planning. Any existing treatment toward stabilization should be maintained.
- If there is evidence of a disorder but the diagnosis and/or treatment recommendations are unclear, the counselor should begin the process of obtaining this information from collaterals.

- The client's history adds depth to our knowledge of the client and can be useful both to confirm an established diagnosis and to provide insight into patterns that may emerge.
- Let's discuss some examples:
  - ***ASK***—If a client comes into the clinician's office under the influence of alcohol, it is reasonable to suspect alcohol dependence, but what is the only diagnosis that can be made based on that evidence?
    (Answer: Alcohol intoxication)
    - Of course, this warrants further investigation because on the one hand, false positives can occur, while on the other, detoxification may be needed.
  - ***Example***—If a client comes into the clinician's office and has not had a drink in 10 years, attends Alcoholics Anonymous (AA) meetings three times per week, and had four previous detoxification admissions, the clinician can make a diagnosis of alcohol dependence (in remission at present). The clinician can also predict that 20 years from now that client will still have the diagnosis of alcohol dependence since the history of alcohol dependence and treatment sustains a lifetime diagnosis of alcohol dependence.
  - ***ASK***—If a client comes into the clinician's office and says she hears voices, regardless of whether or not the client is sober currently, what diagnosis should be made on that basis?
    (Answer: No diagnosis should be made on that basis alone.)
    - There are many reasons people hear voices. They may be related to substance-related syndromes (e.g., substance-induced psychosis or *hallucinosis*, which is the experience of hearing voices that the client knows are not real).
    - With COD, most causes for hearing voices (i.e., hallucinations) will be independent of substance use such as schizophrenia, schizoaffective disorder, affective disorder with psychosis or dissociative hallucinosis related to PTSD.
  - ***Example***—If the client states he has heard voices, though not as much as he used to, that he has been clean and sober for four years, that he remembers to take his medication most days though every now and then he forgets, and that he had multiple psychiatric hospitalizations for psychosis 10 years ago but none since, then the client clearly has a diagnosis of psychotic illness (probably schizophrenia or schizoaffective disorder). Given the client's continuing symptoms while clean and sober and on medication, it is quite possible that the diagnosis will persist.

Documenting Prior Diagnoses

- ***Principle #2:*** It is important to document prior diagnoses and gather information related to current diagnoses, even though substance abuse treatment counselors may not be licensed to make a mental disorder diagnosis.
- Diagnoses established by history should not be changed at the point of initial assessment. Issues related to diagnosis should be raised by the counselor with the clinical supervisor or at a team meeting.
- If the clinician suspects a long-established diagnosis may be invalid, *before* recommending diagnostic re-evaluation it is important that the clinician take the time to:
  - Gather additional information
  - Consult with collaterals
  - Get more careful and detailed history
  - Develop a better relationship with the client
- During the initial assessment process, data gathered by substance abuse treatment counselors can assist the diagnostic process by either supporting the findings of the existing mental health assessment, or providing useful background information in the event a new mental health assessment is conducted.
- However, the key to assisting the diagnostic process is not merely to gather lists of past and present symptoms. The key is to connect those symptoms to periods in the client's life that are helpful to the diagnostic process—namely before the onset of substance use and during periods of abstinence (or during times of limited use).

Linking Mental Symptoms to Specific Periods

- ***Principle #3:*** For diagnostic purposes, it is almost always necessary to tie mental symptoms to specific periods of time in the client's history, in particular those times when an active substance use disorder was not present.
- The mental disorder and substance use history have in the past been collected separately and independently. As a result, the opportunity to evaluate interaction between mental symptoms and periods of abstinence, *which is the most important diagnostic information beyond the history*, has been lost routinely. Newer and more detailed assessment tools overcome these divisions.
  - In the TIP text there is information on helpful instruments such as the M.I.N.I. Plus (TIP pages 80 and 492) (Sheehan et al. 1998), adaptations of the Timeline Follow Back Method (TIP page 89) (www.dartmouth.edu/~psychrc/instru.html) developed by Sobell and Mueser (Mueser et al. 1995*b*; Sobell et al. 1979), and others.
- The substance abuse treatment counselor can proceed in two (2) ways:
  1. Inquire whether any mental symptoms or treatments identified in the screening process were present:
     a. during periods of 30 days of abstinence or longer
     b. before onset of substance use.

     Example—"Did this symptom or episode occur during a period when you were clean and sober for at least 30 days?"
  2. More reliable information may result by defining with the client specific time periods where the substance use disorder was in remission, and then getting detailed information about mental symptoms, diagnoses, impairments, and treatments during those periods of time.

     Example—"Can you recall a specific period when you were not using? Did these symptoms [or whatever the client has reported] occur during that period?"
- During this latter process, the counselor can:
  - Use one of the medium-power symptom screening tools as a guide.
  - Use the handy outlines of the DSM-IV-TR criteria for common disorders and inquire whether those criteria symptoms were met, whether they were diagnosed and treated, and if so, with what methods and how successfully.
  - This information can suggest or support the accuracy of diagnoses. Documentation also can facilitate later diagnostic assessment by a mental-health-trained clinician.

5 minutes

OH #4B-16

Step 7: Determine Disability and Functional Impairment

Introduction

- The last step we will examine today is Step 7: Determine disability and functional impairment.
- ***ASK***—How is disability and functional impairment determined in your programs? How do you use this information?

Trainer Note:

- Elicit a few responses. Use these as springboards for the following points:

- Information regarding a client's current functional impairment and baseline functional impairment helps identify if case management and/or higher levels of support are needed.
- This step also relates to the determination of level of care requirements.
- Assessment of current cognitive capacity, social skills, and other functional abilities also is necessary to determine if there are deficits that may require modification in the treatment protocols of relapse prevention efforts or recovery programs.

3 minutes

OH #4B-17

TIP Exercise—Step 7 Application to Case Examples

- With your partner, look over the text box at the bottom of page 89 or at the top of page 90 *(Allow participants to access pages 89-90.)*
- Look at only one (1) of the clients. In your opinion, how useful was the determination of disability and functional impairment for the counselor? For the client? You have three (3) minutes.

Trainer Note:

- Call time after three (3) minutes.
- Elicit responses. Use these as segues to make the following points:

Assessing Functional Capability

- Baseline level of impairment is determined by identifying periods of extended abstinence and mental health stability (greater than 30 days) according to the methods described in Step 6.
- Current level of impairment is determined by assessing functional capabilities and deficits in each of the following areas:
  - Is the client capable of living independently (in terms of independent living skills, not in terms of maintaining abstinence)? If not, what types of support are needed?
  - Is the client capable of supporting himself financially? If so, through what means? If not, is the client disabled, or dependent on others for financial support?
  - Can the client engage in reasonable social relationships? Are there good social supports? If not, what interferes with this ability, and what supports would the client need?
  - What is the client's level of intelligence? Is there a developmental or learning disability? Are there cognitive or memory impairments that impede learning? Is the client limited in ability to read, write, or understand? Are there difficulties with focusing, concentrating, and completing tasks?

OH #4B-18

- For individuals with COD, the impairment may be related to intellectual/cognitive ability or the mental disability. These disorders may exist in addition to the substance use disorder. The clinician should try to establish both level of intellectual/cognitive functioning in childhood and whether any impairment persists, and if so, at what level, during the periods when substance use is in full or partial remission.

Determining the Need for "Capable" or "Enhanced" Level Services

- A specific tool to assess the need for "capable" or "enhanced" level services for persons with COD currently is not available. The consensus panel recommends a process of "practical assessment" that seeks to match the client's assessment (mental health, substance abuse, level of impairment) to the type of services needed.
  - The individual may even be given trial tasks or assignments to determine in concert with the counselor if her performance meets the requirements of the program being considered.

3 minutes

Wrap up

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Quickly review the TIP ZIP test key.
- Celebrate by presenting small prizes such as candy or markers to participants with the most correct answers.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

MODULE 4B
Option for Advanced Participant Groups

Trainer Note:

- This session continues examination begun in Module 4A—Advanced of how closely program assessment procedures match the assessment steps recommended in TIP 42. Through reflection and discussion, participants may make suggestions for performance improvement in their program assessment procedures.
- Participants should be encouraged to interact with the TIP text as much as possible as it contains information useful at many levels of proficiency.

Use of Program Documentation

- If the trainer is part of the program staff, such as the clinical supervisor, randomly selected charts or program documentation could be reviewed and discussed by the participants. Discussion could include how well the participants' initial perceptions regarding program performance were supported by the documentation.

Group Assignments

- Depending on the needs of the program and the number of participants:
  - Small groups each can be assigned a different step as their focus during the entire session, or
  - Small groups each can be assigned subtopics within the different steps as that step becomes the focus of the session.

Suggested Timetable for Module 4B—Advanced

Introduction ■ Reconvening and Review of Module 4A	5 minutes
TIP ZIP Test ■ *Optional*	*5 minutes*
Step 3: Screen for & Detect Co-Occurring Disorders ■ Safety Screening ■ Screening for Past and Present Mental Disorders ■ Screening for Past and Present Substance Use Disorders ■ Trauma Screening	10 minutes
Step 4 and Step 5: Determine Quadrant & Level of Care ■ Determination of Quadrant Assignment ■ Determining Level of Care	10 minutes
Step 6: Determine Diagnosis ■ Importance of Client History ■ TIP Exercise—Application to Case Examples ■ Documenting Prior Diagnosis ■ Linking Mental Symptoms to Specific Periods	10 minutes
Step 7: Determine Disability & Functional Impairment ■ Introduction ■ TIP Exercise—Application to Case Examples ■ Assessing Functional Capability ■ Determining Need for “Capable” or “Enhanced” Services	5 minutes
Wrap up ■ TIP ZIP Test Review—*Optional*	*3 minutes*
TOTAL *(not including optional activities)*	**45 minutes**

5 minutes

Introduction

Trainer Note:

- The Introduction for the advanced option follows the same format as for the non-advanced training.
- ***Follow the training format beginning on page 5.***

- Reconvening and Review of Module 4A

5 minutes

TIP ZIP Test

Trainer Note:

- This activity is optional and may be deleted to allow time for other discussion. If the trainer chooses to use the TIP ZIP Test, the advanced option follows the same format as for the non-advanced training. ***Follow the training format beginning on page 7.***

10 minutes

Step 3: Screen for and Detect Co-Occurring Disorders

Trainer Note:

- The trainer will need to determine how much time to allow for discussion. Remember to allow a minute or two for small groups to report out.

- Participants briefly review Step 3 beginning on page 75. Discussion in small groups or dyads evaluates their program's:
  - Safety screening
  - Screening for past and present mental disorders
  - Screening for past and present substance use disorder
  - Trauma screening

10 minutes

Step 4 and Step 5: Determine Quadrant and Level of Care

Trainer Note:

- The trainer will need to determine how much time to allow for discussion. Remember to allow a minute or two for small groups to report out.

- Participants briefly review Steps 4 and 5 on pages 82 and 84. Discussion can address:
  - How severity quadrants are used or could be used in current program assessment
  - Procedures, problems and suggestions related to determining level of care

10 minutes

Step 6: Determine Diagnosis

Trainer Note:

- The trainer will need to determine how much time to allow for discussion. Remember to allow a minute or two for small groups to report out.

- Participants briefly review Step 6 beginning on page 86. Discussion can address program procedures for determining diagnosis, related problems, and possible improvements. Subtopic areas for this discussion include:
  - Importance of client history
  - Documenting prior diagnoses
  - Linking mental symptoms to specific periods

5 minutes

Step 7: Determine Disability and Functional Impairment

Trainer Note:

- The trainer will need to determine how much time to allow for discussion activity. Remember to allow a minute or two for small groups to report out.

- Participants briefly review Step 7 beginning on page 89. Discussion can address program procedures and problems related to:
  - Assessing functional capability
  - Determining need for “capable” or “enhanced” services

3 minutes

Wrap up

Trainer Note:

- ***Follow the training format beginning on page 30.***

Module 4B
TIP ZIP TEST

1. T or F—Safety screening requires that early in the interview the clinician ask the client directly (and anyone else providing information) if the client has any immediate impulse to engage in violent or self-injurious behavior, or is in any immediate danger from others. *(p. 75)*

2. T or F—At the time of admission to substance abuse treatment the counselor must disregard any previous diagnosis of mental illness in the client's history until it is clear whether or not the substance use produced symptoms that mimicked mental illness. *(p. 86)*

3. T or F—When screening for a history of trauma or a preliminary diagnosis of PTSD it is essential that questioning be quite thorough so the clinician can obtain an accurate description of the traumatic events. *(p. 82)*

4. T or F—Every state mental health system uses the same criteria for determining who can be considered seriously mentally ill (and therefore eligible to be considered a mental health priority client). *(p. 83)*

5. T or F—Alcohol and drug abuse are among the highest predictors of dangerousness to self or others. *(p. 76)*

6. If a client comes into the clinician's office under the influence of alcohol, what diagnosis can be made based on that evidence?

   _____ *(p. 86)*

7. If a client comes into the clinician's office and says she hears voices, what diagnosis can be made on that basis regardless of whether or not she is sober?

   _____ *(pp. 86-87)*

Module 4B
TIP ZIP TEST—KEY

1. ***T*** or F—Safety screening requires that early in the interview the clinician ask the client directly (and anyone else providing information) if the client has any immediate impulse to engage in violent or self-injurious behavior, or is in any immediate danger from others. *(p. 75)*

2. T or ***F***—At the time of admission to substance abuse treatment the counselor must disregard any previous diagnosis of mental illness in the client's history until it is clear whether or not the substance use produced symptoms that mimicked mental illness. *(p. 86)*

3. T or ***F***—When screening for a history of trauma or a preliminary diagnosis of PTSD it is essential that questioning be quite thorough so the clinician can obtain an accurate description of the traumatic events. *(p. 82)*

4. T or ***F***—Every state mental health system uses the same criteria for determining who can be considered seriously mentally ill (and therefore eligible to be considered a mental health priority client). *(p. 83)*

5. ***T*** or F—Alcohol and drug abuse are among the highest predictors of dangerousness to self or others. *(p. 76)*

6. If a client comes into the clinician's office under the influence of alcohol, what diagnosis can be made based on that evidence?
   Alcohol intoxication *(p. 86)*

7. If a client comes into the clinician's office and says she hears voices, what diagnosis can be made on that basis regardless of whether or not she is sober?
   No diagnosis can be made *(pp. 86-87)*

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 4B

Introduction

Assessment:
Step 3–Step 7

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

TIP Chapter 4: Assessment

- Module 4A
  - Screening and Step 1–Step 2
- **Module 4B**
  - The Assessment Process: Step 3–Step 7
- Module 4C
  - The Assessment Process: Step 8–Step 12

12 Step Assessment Process

1: Engage the client

2: Identify & contact collaterals to gather additional information

3: Screen for & detect COD

4: Determine quadrant & locus of responsibility

5: Determine level of care

6: Determine diagnosis

7: Determine disability & functional impairment

8: Identify strengths & supports

9: Identify cultural & linguistic needs & supports

10: Identify problem domains

11: Determine stage of change

12: Plan treatment

Screening

- Screening for COD seeks to answer a “yes” or “no” question:
  - Does the substance abuse client being screened show signs of a possible mental health problem?

OR

  - Does the mental health client being screened show signs of a possible substance abuse problem?

Step 3: Screen and Detect COD

Screen for:

- Acute safety risk
- Past and present mental health symptoms/disorders
- Past and present substance abuse disorders
- Cognitive and learning deficits
- Past and present victimization and trauma

Screening for Substance Use Disorder *(Mental Health settings)*

- Substance abuse symptom checklists
- Substance abuse severity checklists
- Formal screening tools that work around denial
- Screening of urine, saliva, or hair samples

12 Step Assessment Process

1: Engage the client

2: Identify & contact collaterals to gather additional information

3: Screen for & detect COD

4: Determine quadrant & locus of responsibility

5: Determine level of care

6: Determine diagnosis

7: Determine disability & functional impairment

8: Identify strengths & supports

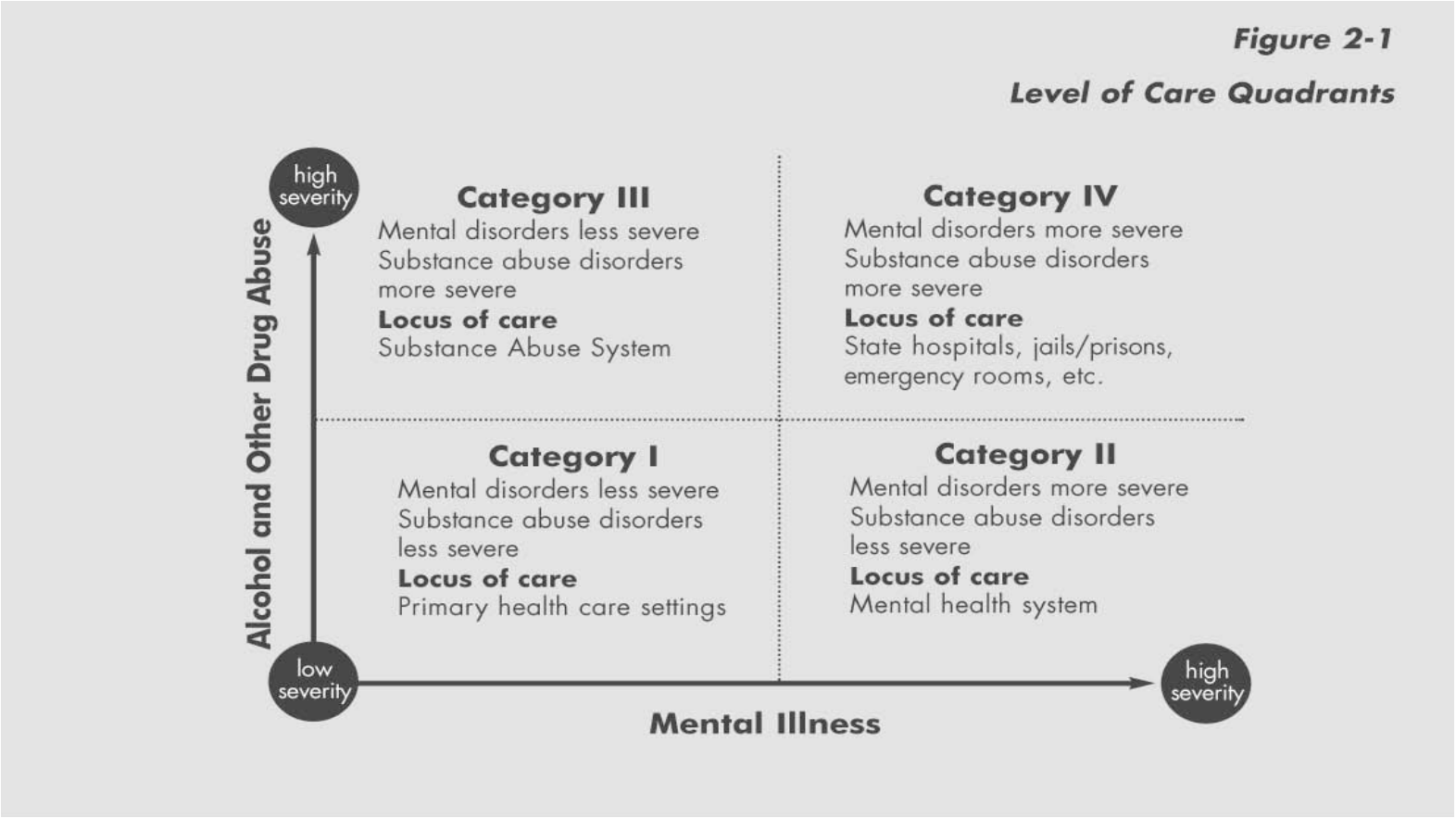
9: Identify cultural & linguistic needs & supports

10: Identify problem domains

11: Determine stage of change

12: Plan treatment

Step 4: Determine Quadrant and Locus of Responsibility



Determination of SMI Status

- What is the State's criteria for SMI?
- How is eligibility established?
- Is the client already receiving mental health priority services?
- Does the client appear to be eligible?

Step 4: Determine Quadrant and Locus of Responsibility

Figure 2-1

Level of Care Quadrants

TIP Exercise—
Cases & Quadrants of Care

With your partner:

- Select one case (Maria M., or George T., or Jane B.) on pp. 69 and 70.
- Change or add information that would result in assignment of that case to a different quadrant.

(1 minute)

12 Step Assessment Process

1: Engage the client

2: Identify & contact collaterals to gather additional information

3: Screen for & detect COD

4: Determine quadrant & locus of responsibility

5: Determine level of care

6: Determine diagnosis

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8: Identify strengths & supports

9: Identify cultural & linguistic needs & supports

10: Identify problem domains

11: Determine stage of change

12: Plan treatment

Level of Care Instruments

ASAM PPC 2R - Dimensions

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions and Complications
- Emotional, Behavioral, or Cognitive Conditions and Complications *(includes risk)*
- Readiness to Change
- Relapse, Continued Use, or Continued Problem Potential
- Recovery/Living Environment

LOCUS - Dimensions

- Risk of Harm
- Functionality
- Comorbidity (Medical, Addictive, Psychiatric)
- Recovery Support and Stress
- Treatment Attitude and Engagement
- Treatment History

12 Step Assessment Process

1: Engage the client

2: Identify & contact collaterals to gather additional information

3: Screen for & detect COD

4: Determine quadrant & locus of responsibility

5: Determine level of care

6: Determine diagnosis

7: Determine disability & functional impairment

8: Identify strengths & supports

9: Identify cultural & linguistic needs & supports

10: Identify problem domains

11: Determine stage of change

12: Plan treatment

Step 6: Determine Diagnosis

- ***Principle 1*—**Diagnosis is established more by history than by current symptom presentation.
- ***Principle 2*—**It is important to document prior diagnoses and gather information related to current diagnoses.
- ***Principle 3*—**It is almost always necessary to tie mental symptoms to specific periods of time in the client's history, in particular times when active substance use disorder was not present.

12 Step Assessment Process

1: Engage the client

2: Identify & contact collaterals to gather additional information

3: Screen for & detect COD

4: Determine quadrant & locus of responsibility

5: Determine level of care

6: Determine diagnosis

7: Determine disability & functional impairment

8: Identify strengths & supports

9: Identify cultural & linguistic needs & supports

10: Identify problem domains

11: Determine stage of change

12: Plan treatment

TIP Exercise—Step 7
Application to Case Examples

- Review with your partner the case on p. 89 *OR* the case on p. 90.
- In your opinion, how useful was the determination of disability and functional impairment:
  - For the counselor?
  - For the client?

(3 minutes)

Assessing Functional Capability

- Is the client capable of living independently? If not, what types of support are needed?
- Is the client capable of supporting himself financially? Through what means? If not, is the client disabled or financially dependent on others?
- Can the client engage in reasonable social relationships? Are there good social supports? If not, what interferes, and what supports are needed?
- What is the client's level of intelligence? Is there a developmental or learning disability? Cognitive or memory impairments? Limited ability to read, write, or understand? Difficulties focusing and completing tasks?

MODULE 4C: Assessment: Step 8—Step 12

Objectives

- Chapter 4 in the TIP presents an approach to comprehensive assessment of clients with COD and has as its purpose to encourage the field to move toward this ideal. In order to adequately address the chapter's main topics of screening and assessment, Module 4 has been designed as a cluster of three (3) 45-minute sessions that build on one another: Module 4A, Module 4B and Module 4C.
  - *Module 4A* addressed screening and Step 1 and Step 2 of the assessment process.
  - *Module 4B* examined Step 3 through Step 7 of the assessment process.
  - ***Module 4C* examines:**

    Step 8: Identify Strengths and Supports

    Step 9: Identify Cultural and Linguistic Needs and Supports

    Step 10: Identify Problem Domains

    Step 11: Determine Stage of Change

    Step 12: Plan Treatment

    Case studies and review of relevant appendices in the TIP text

Trainer Note:

- The following sections refer to Module 4C only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 4C.1-4C.11
- Kitchen timer
- Markers and Post-It Notes for participants to use on their TIP texts
- Newsprint paper—two (2) sheets per small group of four (4) participants
- Masking tape to post Newsprint sheets on wall or easel

Module Design

- This module concludes the (3) three-module presentation of the TIP's 12 Step assessment process. Module 4C is a blend of lecture, activity, and interaction with the TIP text. Discussions are either trainer-led or occur in small groups. The final group activity requires participants to synthesize material presented in all three (3) sessions (Modules 4A, 4B and 4C). Presentation of the rest of the session must be adjusted to allow sufficient time for this final activity.
- The major part of this training session is dedicated to the final group activity: the treatment planning exercise and critique. Participants work on developing or updating a treatment plan from their practice and present it for critique by members of their small groups. Care should be taken that identifying information is not included and that all confidentiality rules are followed.
- Several screening tools are referred to regularly throughout modules 4A through 4C including:
  - Addiction Severity Index (ASI) (McLellan et al. 1992)
  - ASAM PPC-2R (ASAM 2001)
  - Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 1992)
  - CAGE (Mayfield et al. 1974)
  - Dartmouth Assessment of Lifestyle Inventory (DALI) (Rosenberg et al. 1998)
  - Drug Abuse Screening Test (DAST) (Skinner 1982)
  - Global Appraisal of Individual Needs (GAIN) (Dennis 1998)
  - LOCUS (American Association of Community Psychiatrists [AACP] 2000*a*)
  - Mental Health Screening Form-III (MHSF-III) (Carroll and McGinley 2001)

  - Michigan Alcoholism Screen Test (MAST) (Selzer 1971)
  - Simple Screening Instrument for Substance Abuse (SSI-SA) (CSAT 1994*c*)
- For brevity purposes, the full citations for these screening tools are provided here but are omitted from the remainder of the modules.

Seating

- Participants will work in small groups at the end of the module to create a treatment plan. Only ten (10) minutes has been allowed for groups to report out. For each group to have at least two (2) minutes to report, the trainer will need to break the larger group into no more than five (5) small groups of 3-4 participants. This should be done quickly at the start of the session using an icebreaker, numbering off process, or simply by combining existing pairs. *If the number of participants is so large that more than five (5) small groups are required, the trainer will need to lead the final activity as a* ***large group activity*** *instead.*

Discussion Questions

- ***General***—There are many questions interspersed in the script meant to deepen understanding and connect learning to the participants' practice. The trainer may wish to delete certain questions in order to spend more time on those most relevant to participants. The trainer will need to control discussions to adequately cover the material and allow enough time for the final activity.

Option for Advanced Participant Groups

- For participants who are proficient in screening and assessment and for whom the script as written would provide no significant new learning, Modules 4A, 4B and 4C provide an opportunity to examine the screening and assessment processes in their program and compare these to the guidance and recommendations in Chapter 4 of the TIP. Participants can then suggest how performance might be improved in these areas.
- The Option for Advanced Participant Groups begins on page 24 of the training curriculum.

Suggested Timetable for Module 4C	
Introduction ■ Reconvening ■ Introduction to "Considerations in Treatment Matching" Grid	5 minutes
Step 8: Identify Strengths and Supports ■ Application to Case Examples	3 minutes
Step 9: Identify Cultural and Linguistic Needs and Supports ■ Application to Case Examples	5 minutes
Step 10: Identify Problem Domains ■ Application to Case Examples	2 minutes
Step 11: Determine Stage of Change ■ Introduction—*1 minute* ■ TIP Exercise—Application of Stages of Change to Case Example – Group Discussion—*3 minutes* – Report Out—*3 minutes*	7 minutes
Step 12: Plan Treatment ■ Introduction—*1 minute* ■ TIP Exercise—Plan Treatment – Group Discussion—*10 minutes* – Report Out—*10 minutes*	21 minutes
Wrap up	2 minutes
TOTAL	**45 minutes**

5 minutes

OH #4C-1

Introduction

Reconvening

Trainer Note:

- This section serves two (2) purposes: it recalls the assessment steps covered in preceding sessions and it introduces a new framework, the *Considerations in Treatment Matching* grid (p. 97). Because the grid is used often in this session, participants are asked to mark it (e.g., a Post-It Note) to facilitate flipping back and forth in the text.
- The trainer needs to be thoroughly familiar with both the assessment steps and the *Considerations in Treatment Matching* grid and how they relate to each other in order to credibly model for participants the usefulness of both frameworks in the assessment process.
- Check that everyone has a copy of the TIP. Lend copies or have people share.

OH #4C-2

- Today we will conclude our examination of Chapter 4 of TIP 42.
- Please remember, our sessions are meant to familiarize you with the TIP text and are not a substitute for reading it. Much valuable information for clinicians cannot be addressed or addressed in detail here because of time constraints.
- Our last session continued our examination of Chapter 4 by reviewing Step 3 through Step 7 of the assessment process.

OH #4C-3

- In Module 4C, we will continue examination of the steps and focus on Steps 8, 9, 10, 11 and 12. We will also look at application of these steps to case studies in the TIP.
- Notice that each of the steps begins with a verb, an action. The steps organize the assessment process for clinicians by answering the question, “What do I do?”

Introduction to "Considerations in Treatment Matching" Grid

- Next, we will examine another way of looking at this process. On page 97 is Figure 4-3, entitled "Considerations in Treatment Matching." Please turn to page 97. These "considerations" are critical factors that have been determined relevant to matching individual clients to available treatment. *(Allow participants to access page 97.)*
- We will use this grid throughout our session today, so please mark it with a Post-It Note so that you can flip easily to this page.

Trainer Note:

- Allow participants to use Post-It Notes or other ways to mark page.
- Refer to the above slide of the *12 Step Assessment Process* and to the *Considerations in Treatment Matching* grid in the text during the following discussion.

- The Considerations grid offers another format for organizing the information needed in an assessment. It answers three (3) questions for the counselor trying to appropriately match an individual client with COD to available treatment. The three (3) questions are:
  - "What do I need to consider?"
  - "What will that information help me decide?"
  - "What specific data in this area do I need?"

Acute Safety Needs and Steps 1 through Step 3

Trainer Note:

- Acute Safety Needs is the first variable on the left column of the Considerations grid on page 97.

- Let's take a quick look at some of these considerations. On the first row:
- ***ASK***—What do I need to consider?
- ***ASK***—What will the information help me decide?

  (Answer: Determines if there is a need for immediate acute stabilization to establish safety prior to routine assessment.)
- ***ASK***—What specific data in this area do I need?

  (Answer: Key data needed includes:

  – *Immediate risk of harm to self and others*

  – *Immediate risk of physical harm or abuse from others*

  – *Inability to provide for basic self-care*

  – *Medically dangerous intoxication or withdrawal*

  – *Potentially lethal medical condition*

  – *Acute severe mental symptoms.)*
- ***ASK***—Think back to our previous assessment steps. How would we get that data?

  (Answer: Engage the client, gather information from collateral sources, screen the client. In other words, Steps 1-3.)

Quadrant Assignment

- The next consideration is quadrant assignment.
- ***ASK***—What will the information help me decide?

  (Answer: The most appropriate setting for treatment.)

- ***ASK***—What specific data in this area do I need?

  (Answer: Key data would include whether the client's mental illness is severe and persistent, moderate or mild. Also is the substance use disorder high severity or lower severity or in remission? Information related to quadrant assignment was discussed in Step 4.)

Level of Care

- The next variable is level of care.
- ***ASK***—What will level of care help me decide?

  (Answer: The client's program assignment.)

- ***ASK***—What specific data do I need?

  (Answer: Dimensions of assessment of each disorder using criteria such as the ASAM PPC-2R or the LOCUS. This process was discussed in Step 5 and in Chapter 2.)

Diagnosis

- Moving on to the next variable, diagnosis. This information will allow us to select treatment interventions best suited to the individual client. Much of the specific information needed here was discussed last session for Step 6.

Disability

- Continuing on page 98, another consideration is that of disability. This helps us decide if the client has cognitive, functional or skill deficits that may require an "enhanced" level of case management. Are there deficits that would impede standard treatment or require modifications? We concluded last session with Step 7 of the assessment process, which examines the client's disability and functional impairment.

Strengths and Skills, Availability and Continuity of Recovery Support

- The next two (2) variables on page 98 look at the client from the opposite perspective. Consideration of the individual's current strengths and skills will help us organize future treatment around the client's prior successes and interests.
- Consideration of recovery supports will help us determine what personal and treatment related relationships are already available. This will also help determine whether new relationships need to be established and what those relationships may be.
- Data we need regarding strengths and skills are areas where the client is particularly capable in relation to general life functioning, as well as in relation to his or her ability to manage either mental or substance use disorder. These areas are the focus of Step 8.

3 minutes

Step 8: Identify Strengths and Supports

Trainer Note:

- ***Step 8—Step 10 (General comments)***—As in the reconvening section, presentation of the new assessment steps for this session is also done in relation to the *Considerations in Treatment Matching* grid. There is substantial reference to the text. Discussion is mostly trainer-led.

OH #4C-4

- Attention to the strengths and supports often provides a more positive approach to treatment engagement than does focusing exclusively on deficits that need to be corrected. This is true both for clients with serious mental disorders and for people with substance use disorders only.
- How do we identify a client's strengths and supports? On page 91 of the TIP text there are some suggestions. Please turn to page 91, right hand column. *(Allow participants to access page 91.)*
- Questions to the client and collateral informers might focus on:
  - Talents and interests
  - Areas of educational interest and literacy; vocational skill, interest, and ability, such as vocational skills, social skills, or capacity for creative self-expression
  - Areas connected with high levels of motivation to change, for either disorder or both
  - Existing supportive relationships, treatment, peer, or family, particularly ongoing mental disorder treatment relationships (ASAM 2001)
  - Previous mental health services and addiction treatment successes, and exploration of what worked
  - Identification of current successes: What has the client done right recently, for either disorder?
  - Build treatment plans and interventions based on utilizing and reinforcing strengths, and extending or supporting what has worked previously.

Application to Case Examples

- In the text box at the bottom of page 91, Step 8 has been applied to the case examples of George T. and Jane B. Please read over these and then we will discuss them. *(Allow participants to access and read the text box on page 91.)*
- George T. had strengths in three (3) areas:

  1. His desire to maintain his family—which fits under "existing supportive relationships" on the list on page 91
  2. Pride in his job
  3. Attachment to a mutual self-help group for individuals with bipolar disorder—again, an existing supportive relationship. In this case, it is also related to his mental disorder treatment

- George's treatment plan takes advantage of these positives: attending a recovery group managed by the Employee Assistance Program (EAP) at his company (which included regularly monitored urine screens), family counseling sessions, and utilization of his weekly MDDA group for peer support.
- In Jane's case, work is also important. The part time work incorporated her existing interest in animals and the fact that work motivates her to remain medication compliant and stay away from substances.
- ***ASK***—How do you typically assess for client strengths and supports? Do you think you put these to maximum use in the treatment process? Can you give an example?

Trainer Note:

- Elicit answers from volunteer participants. Then, return to presentation.

- Beginning on page 92, Step 8 includes a discussion on the Individual Placement and Support model of psychiatric rehabilitation, as well as a discussion on requirements for Social Security Disability secondary to a mental disorder. We will not address this today, but as always, you are encouraged to read all of the information in the TIP text.

5 minutes

OH #4C-5

OH #4C-6

Step 9: Identify Cultural and Linguistic Needs and Supports

- Cultural assessment of individuals with COD is not substantially different from cultural assessment for individuals with substance abuse or mental disorders only. However, there are three (3) issues the TIP calls particular attention to:
  - Not fitting into the treatment culture (do not fit into either substance abuse or mental health treatment culture) and conflict in treatment
  - Cultural and linguistic service barriers
  - Problems with literacy
- Individuals with COD and SMI tend not to fit into existing treatment cultures. Most of these clients are aware of a variety of different attitudes and suggestions toward their disorders that can affect relationships with others.
- ***ASK***—What attitudes might clients in the mental health system have towards substance abusers? How about attitudes in the substance abuse treatment systems towards mental illness? What conflicts in treatment can result from two different systems? What effect would that have on a COD client?
- Also, traditional culture carriers (parents, grandparents) may have different views of the problems and the most appropriate treatment for individuals with COD.
- ***ASK***—To get a sense of this, let's think of culture carriers we are very familiar with, such as our family or extended family members or even our boss and co-workers. Imagine a mental illness diagnosis and a substance abuse diagnosis for yourself. How might some of your family or co-workers view your problems? What would they think of treatment? Would the specific diagnosis affect whether or not you could count on their support? How might their views or reactions affect you and your treatment?
- The TIP suggests some specific considerations to explore with the client on page 93:
  - How are your substance abuse and mental health problems defined by your parents? Peers? Other clients?
  - What do they think you should be doing to remedy these problems?
  - How do you decide which suggestions to follow?
  - In what kinds of treatment settings do you feel most comfortable?
  - What do you think I (the counselor) should be doing to help you improve your situation?

- Now let's take a look at how the Considerations grid on page 98 approaches this information. *(Allow participants to access page 98.)*
- At the bottom of the page, in the Cultural Context row we find that there are several areas we need to understand about the client before making decisions about treatment interventions and settings that will be a good match and therefore have a good chance of succeeding. These include:
  - *Ethnic or linguistic culture identification.* The example given in Figure 4.3 is of a client attached to traditional American-Indian healing practices. This type of information helps determine the most appropriate interventions for this particular client, in other words, the interventions most likely to be successful with this individual.
  - Access to COD treatment is affected by cultural or linguistic barriers. For example, if a client only reads or speaks a language other than English.
  - Access can also be affected if the client is fluent but cannot read or write. We often take for granted the degree to which we live and work in a text-based culture. Not everyone is part of this culture.
- ***ASK***—Think of the routine tasks and activities associated with treatment in your program. How accessible is such treatment for someone that cannot read or write or can do so only at a very low level? Someone whose way of communicating and understanding does not include the written word?
- There are other groups that we may not usually associate with a "culture" but which exert the same powerful influence on the client. Some are treatment related, such as the 12-Step recovery culture. Also, cultural identification may be related to gender or sexual orientation or even rural vs. urban lifestyles and values.
- The assessment process must address specifically whether issues of culture and language prevent access to care and if so, determine some possibilities for providing more individualized intervention or for integrating intervention into naturalistic culturally and linguistically appropriate human service settings.

Application to Case Examples

- On pages 92 and 93, the TIP provides some application of Step 9 to our case examples. Please turn to page 92. *(Allow participants to turn to page 92.)*

Case 1

Maria M. initially had difficulty identifying herself as being a victim of trauma, both because she had normalized her perception of her early family experience with her abusive father, and because she had received cultural reinforcement in the past that condoned the behavior of her abusive boyfriend as "normal machismo."

Referral to a group that included other Hispanic women who also had suffered abuse was very helpful to her. With the help of the group, she began to recognize the reality of the impact that trauma had in her life.

Case 2

George T. originally was referred to Cocaine Anonymous (CA) by his counselor because the counselor knew of several local meetings with a large membership of African-American men. When George T. went, however, he reported back to the counselor that he did not feel comfortable there.

First, he felt that as a family man with a responsible job he had pulled himself out of the "street culture" that was prevalent at the meeting. Second, unlike many people with COD who feel more ashamed of mental disorders than addiction, he felt more ashamed at the CA meeting than at his support group for persons with mental disorders.

Therefore, for George, it was more "culturally appropriate" to refer him to 12-Step meetings attended by other middle class individuals (regardless of race) and to continue to encourage him to attend his MDDA support group for his mental disorder.

2 minutes

OH #4C-7

Step 10: Identify Problem Domains

- Individuals with COD may have difficulties in multiple life domains (e.g., medical, legal, vocational, family, social). Research has shown the value of providing assistance in each problem area in promoting better outcomes (McLellan et al. 1997).

Application to Case Examples

On page 93, Step 10 is applied to George's case.

Case 2

Evaluation of George T. revealed several interrelated problem domains. First, it was established that work represented a major problem area, and that he risked losing his job if he did not comply with treatment. Further inquiry into the details of this expectation led the counselor to discover that the client had been evaluated by the Employment Assistance Program (EAP) and had a very specific requirement to maintain cocaine abstinence with mandatory urine screens, meet treatment program attendance requirements, and adhere to a lithium treatment regimen, with mandatory reports of lithium levels.

- ***ASK***—How could the counselor use this information to create a plan that increases George's likelihood of successful outcomes? What effect would ignoring these problem domains when planning treatment have on George?
- Look in the Considerations grid on page 99. *(Allow participants to access page 99.)*
- In the Problem Domains row, we see that we are trying to "determine problems to be solved specifically, and opportunities for contingencies to promote treatment participation." The key data we need to have is if there are impairments, needs or strengths in the various areas or domains of the client's life. Each may involve factors that affect treatment motivation and participation (McLellan et al. 1993, 1997), factors the clinician can use in tailoring the treatment plan.
- A tool that is used widely to identify and quantify addiction-related problems in multiple domains is the ASI. It permits *identification of problem domains* and is used most effectively as part of a comprehensive assessment. There is more information on the ASI in this chapter and in Appendix G.

7 minutes

SOC

Step 11: Determine Stage of Change

Trainer Note:

- ***Step 11: Determine Stage of Change***—The Stages of Change (Prochaska and DiClemente 1992) can be confusing for anyone hearing the material for the first time. The trainer must be thoroughly familiar with the stages and comfortable using examples from everyday life or program situations to explain them, if needed.
- A brief TIP Exercise (discussion) is included. In small groups, participants assign a stage of change to each problem in one of the case examples. Then, when groups report their answers, the remaining participants are asked if they agree. Both the small group and participants from the larger group will need to provide reasons for their opinions. This will provide opportunity to uncover areas of confusion and re-explain if necessary. Whenever possible, the trainer should guide peers in the larger group to provide needed correction.

OH #4C-8

- A key evidence-based best practice for treatment matching of individuals with COD is the matching of interventions not only to specific diagnosis, but also to the client's stage of change. Stage of change refers to how ready a client is to change his or her behavior.
- In substance abuse treatment settings, determining the client's stage of change usually involves use of the Stages of Change developed by Prochaska and DiClemente (1992). These five (5) stages are: precontemplation, contemplation, preparation (or determination), action, maintenance, and relapse. Explanations can be found on page 94. *(Allow participants to access page 94.)*
- The bulleted list on the right column provides an example of how the stage of change can be determined clinically by interviewing the client and evaluating the client's responses in terms of stages of change.
  - For each problem, select the statement that most closely fits the client's view of that problem:
    - No problem and/or no interest in change (Precontemplation)
    - Might be a problem; might consider change (Contemplation)

- Definitely a problem; getting ready to change (Preparation)
- Actively working on changing, even if slowly (Action)
- Has achieved stability, and is trying to maintain (Maintenance)

- ***ASK***—Why would readiness to change matter? How would your interventions differ for a client who has recognized he has a problem and wants help vs. for a client who truly believes he does not have a problem and has no interest in changing?
- Questionnaires such as the URICA (information is available in Appendix G) (McConnaughy et al. 1983) or the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) (Miller and Tonigan 1996) are also useful in determining the client's stage of change.
- Ideally, stage of change assessment will be applied separately to each mental disorder and to each substance use disorder. For example, a client may be willing to take medication for a depressive disorder, but unwilling to discuss trauma issues (as in Case 1, Maria M.); or motivated to stop cocaine, but unwilling to consider alcohol as a problem (as in Case 2, George T.).

SOC

TIP Exercise—Application of Stages of Change to Case Example

- Application of Step 11 to a case example is found on the bottom of page 94. *(Allow participants to access page 94.)*

Case Example

A 50-year-old Liberian woman with a diagnosis of paranoid schizophrenia, Lila B. illustrates the existence of differential stages of change for mental and substance abuse problems. The client permitted the case manager nurse to come to her home to give her intramuscular antipsychotic injections for her "nerves," but would not agree to engage in any other treatment activity or acknowledge having a serious mental disorder. She also had significant alcohol dependence, with an alcohol level of 0.25 to 0.3 most of the time, with high tolerance. She denied adamantly that she had used alcohol in the last 18 months, stating that her liver was impaired and therefore unable to get rid of the alcohol. She was able to agree that she had a "mysterious alcohol level problem" that might warrant medical hospitalization for testing and perhaps treatment, as well as evaluation of her recent onset rectal bleeding.

3 minutes

OH #4C-9

Group Discussion

- Using the case of Lila B. on page 94, what stage of readiness to change would you and your partners assign the client regarding her:
  - Mental disorder
  - Substance use disorder
  - Give reasons
- You will have three (3) minutes.

Trainer Note:

- Set timer for three (3) minutes. Call time.

3 minutes

Report Out

Trainer Note:

- Ask a few pairs to share their results for mental illness. Make sure they include their reasons for stage of change choice. Ask the rest of participants if they agree or disagree and why.
- Ask a few groups to share their results for substance use. Make sure they include their reasons for stage of change choice. Ask the rest of participants if they agree or disagree and why.
- Correct any misunderstanding of the stages if needed.

21 minutes

Step 12: Plan Treatment

Trainer Note:

- This section concludes the three (3) modules on assessment. After a brief set-up, small groups are asked to develop a treatment plan using the format on page 96 of the TIP. Groups may use Maria M. or Jane B. from the case studies. Or, if participants all work for the same program/agency, they may prefer to use a case all group members are familiar with. At least two (2) problems should be addressed.
- Groups will post their large note sheets on the wall and then make a 1-minute presentation with one (1) minute for discussion and/or response by the larger group or trainer. Because of time constraints, the treatment plans may be simplistic and incomplete. However, the purpose is for participants to practice the process and for the trainer to uncover areas of misunderstanding.

OH #4C-10

- A major goal of the screening and assessment process is to ensure the client is matched with appropriate treatment. Since clients with COD are not all the same, program placements and treatment interventions should be matched individually to the needs of each client.
- Treatment planning for individuals with COD and associated problems should be designed so that each disorder or problem has a specific intervention that is matched to problem or diagnosis, as well as to stage of change and external contingencies.
- Figure 4-2 on page 96 shows a sample treatment plan consisting of the sproblem, intervention, and goal. Please turn to page 96. *(Allow participants to access page 96.)*

- The case of George T. is used. Note that the problem description in the left column presents not only the diagnosis but a variety of information bearing on the problem, including stage of change and client strengths. This illustrates how a client may be at one stage of readiness to change for one problem and at a very different stage for another problem.
  - For example, for his cocaine dependence problem, George T. is at the action stage. In other words, he has already acknowledged he has a problem, and has begun actively changing his behavior, not just thinking about it or preparing to change.
  - As for the alcohol abuse, he is at the precontemplation stage and convinced he does not have a problem and therefore does not need to change. The goal, therefore, is to move him into the contemplation phase where he would be considering the possibility that he might have a problem and might need to change.
  - The type of intervention George T. is ready for with this problem is very different than what he is ready for with his cocaine dependence.
  - Regarding his bipolar disorder, George T. is past the action stage and is already in maintenance, where he has achieved stability and is trying to maintain it.
- Also note that no specific person is recommended to carry out the intervention proposed in the second column, since a range of professionals might carry out each intervention appropriately.

TIP Exercise—Plan Treatment

Trainer Note:

- Because of time constraints for the final activity's report out, it is recommended that participants be divided into no more than five (5) small groups of 3-4 participants. *If the number of participants is so large that more than five (5) small groups are required, the trainer will need to lead this as a* ***large group activity*** *instead.*
- If led as a large group activity, the trainer should use a blank overhead or large note paper to write out the groups suggested plans.
- The trainer will need to have prepared cue questions for the large group in advance.

10 minutes

OH #4C-11

Group Discussion

- We have spent three (3) modules discussing the assessment process that allows us to plan treatment. So, with your partners spend the next ten (10) minutes developing a treatment plan grid similar George's. You may use the case of Maria M. or Jane B. Information on Maria M. can be found on pages 69, 87, 89, and 92. Information on Jane B. is on pages 70, 83, and 91.

Trainer Note:

- If participants are familiar with the same clients, they may use a client from their practice.

- Obviously there is not enough time for a thorough job, but address at least two (2) problems. Take into account related information bearing on the problem such as strengths, cultural issues, and stage of readiness to change regarding each problem. Also, include recommended interventions and goals.
- Please use your large note sheets so we can all see when you present.

Trainer Note:

- Set timer for ten (10) minutes. Call time.

10 minutes

Report Out

Trainer Note:

- Have groups display their grid and share how they addressed one (1) problem.
- Have larger group ask questions or provide feedback, if needed.
- Congratulate and thank all groups for their participation.

2 minutes

Wrap up

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

MODULE 4C
Option for Advanced Participant Groups

Trainer Note:

- This session should continue examination begun in Module 4A—Advanced and 4B—Advanced of how closely program assessment procedures match the assessment steps recommended in TIP 42. Through reflection and discussion, participants may make suggestions for performance improvement in their program assessment procedures.
- Participants should be encouraged to interact with the TIP text as much as possible as it contains information useful at many levels of proficiency.

Use of Program Documentation

- If the trainer is part of the program staff, such as the clinical supervisor, randomly selected charts or program documentation could be reviewed and discussed by the participants. Discussion could include how well the participants' initial perceptions regarding program performance were supported by the documentation.

Group Assignments

- Depending on the needs of the program and the number of participants:
  - Small groups each can be assigned a different step as their focus during the entire session, or
  - Small groups each can be assigned subtopics within the different steps as that step becomes the focus of the session.

Suggested Timetable for Module 4C—Advanced	
Introduction ■ Reconvening ■ Introduction to "Considerations in Treatment Matching" Grid	5 minutes
Step 8: Identify Strengths and Supports	7 minutes
Step 9: Identify Cultural and Linguistic Needs and Supports	7 minutes
Step 10: Identify Problem Domains	7 minutes
Step 11: Determine Stage of Change	7 minutes
Step 12: Plan Treatment	7 minutes
Wrap up	5 minutes
TOTAL	**45 minutes**

5 minutes

Introduction

Trainer Note:

- The Introduction for the advanced option follows the same format as for the non-advanced training.
- ***Follow the training format beginning on page 5.***

- Reconvening
- Introduction to "Considerations in Treatment Matching" Grid

7 minutes

Step 8: Identify Strengths and Supports

Trainer Note:

- The trainer will need to determine how much time to allow for discussion. Remember to allow a minute or two for small groups to report out.

- Participants briefly review Step 8 beginning on page 91. Discussion can then address the bulleted list on page 91, how well client strengths and supports are typically identified during the assessment process and how such identification could be improved.

7 minutes

Step 9: Identify Cultural and Linguistic Needs and Supports

Trainer Note:

- The trainer will need to determine how much time to allow for discussion. Remember to allow a minute or two for small groups to report out.

- Participants briefly review Step 9 beginning on page 92. Discussion can address how their program addresses identification of issues related to:
  - COD patients not fitting into existing treatment cultures
  - Service barriers related to culture
  - Service barriers related to language
  - Service barriers related to literacy

7 minutes

Step 10: Identify Problem Domains

Trainer Note:

- The trainer will need to determine how much time to allow for discussion. Remember to allow a minute or two for small groups to report out.

- Participants briefly review Step 10 beginning on page 93. Discussion can address how problem domains are typically identified, how effective is this method (or instrument), how clear is the assessment of how each disorder interacts with the problems in each domain, and what can be improved in this area?

7 minutes

Step 11: Determine Stage of Change

Trainer Note:

- The trainer will need to determine how much time to allow for discussion. Remember to allow a minute or two for small groups to report out.

- Participants briefly review Step 11 beginning on page 94. Discussion can address if and how the client's stage of readiness to change for each disorder is identified, how well intervention are matched to the client's stage of change, and how could this Step be carried out in their program more effectively?

7 minutes

Step 12: Plan Treatment

Trainer Note:

- The trainer will need to determine how much time to allow for discussion. Remember to allow a minute or two for small groups to report out.

- Participants briefly review Step 12 beginning on page 95 with special attention to the *Considerations in Treatment Matching* grid on page 97. Discussion can address how well do the program's treatment planning procedures typically match each client's individual needs? What mechanisms exist by which all of the information in the Considerations in Treatment Matching grid is identified and addressed in the plan? Where are the gaps and how might they be addressed?

5 minutes

Wrap up

Trainer Note:

- ***Follow the training format on page 23.***

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 4C

Introduction

Assessment:
Step 8–Step 12

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

TIP Chapter 4: Assessment

- Module 4A
  - Screening and Step 1–Step 2
- Module 4B
  - The Assessment Process: Step 3–Step 7
- **Module 4C**
  - The Assessment Process: Step 8–Step 12

12 Step Assessment Process

1: Engage the client

2: Identify & contact collaterals to gather additional information

3: Screen for & detect COD

4: Determine quadrant & locus of responsibility

5: Determine level of care

6: Determine diagnosis

7: Determine disability & functional impairment

8: Identify strengths & supports

9: Identify cultural & linguistic needs & supports

10: Identify problem domains

11: Determine stage of change

12: Plan treatment

12 Step Assessment Process

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10: Identify problem domains

11: Determine stage of change

12: Plan treatment

Cultural Assessment—COD

- Three important issues for those with COD:
  - Not fitting into the treatment culture (do not fit into either substance abuse or mental health treatment culture) and conflict in treatment
  - Cultural and linguistic service barriers
  - Problems with literacy

12 Step Assessment Process

1: Engage the client

2: Identify & contact collaterals to gather additional information

3: Screen for & detect COD

4: Determine quadrant & locus of responsibility

5: Determine level of care

6: Determine diagnosis

7: Determine disability & functional impairment

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12 Step Assessment Process

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9: Identify cultural & linguistic needs & supports

10: Identify problem domains

11: Determine stage of change

12: Plan treatment

TIP Exercise—Stages of Change

Using the case on p. 94, what stage of readiness to change would you and your partner(s) assign the client regarding her:

a) Mental disorder?

b) Substance use disorder?

c) Give reasons

Stages of Change

- Precontemplation
- Contemplation
- Preparation
- Action
- Maintenance

(3 minutes)

12 Step Assessment Process

1: Engage the client

2: Identify & contact collaterals to gather additional information

3: Screen for & detect COD

4: Determine quadrant & locus of responsibility

5: Determine level of care

6: Determine diagnosis

7: Determine disability & functional impairment

8: Identify strengths & supports

9: Identify cultural & linguistic needs & supports

10: Identify problem domains

11: Determine stage of change

12: Plan treatment

TIP Exercise—Plan Treatment

With your group, use format on p. 96 to . . .

- Plan treatment for:
  - Maria M. (pp. 69, 87, 89, 92)
    or Jane B. (pp. 70, 83, 91)
- Address at least two (2) problems
- Include for each:
  - Related information (strengths, cultural issues, etc.)
  - Stage of readiness to change
  - Recommended interventions
  - Goals

(10 minutes)

MODULE 5A: Strategies for Working with Clients with Co-Occurring Disorders: Guidelines for a Successful Therapeutic Relationship

Objectives

- Chapter 5 in the TIP text is divided into two (2) sections: a section providing guidelines for building successful therapeutic relationships, and a section outlining specific techniques that are effective in counseling clients with COD. Module 5 has therefore been divided into two (2) 45-minute sessions:
  - ***Module 5A*** reviews the guidelines for maintaining a successful therapeutic relationship with a client who has COD.
  - Module 5B examines techniques for working with clients with COD.
  - Included in these modules is discussion of text content, a focus on the *Advice to Counselors* text boxes, and references to the relevant appendices in the TIP text.

Trainer Note:

- The following sections refer to Module 5A only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 5A.1—5A.14
- Kitchen timer
- Markers and Post-It Notes for participants to use on their TIP texts

Module Design

- Module 5A is a blend of small group (or dyadic) discussion, brief lecture, and constant interaction with the TIP text. The primary objectives of this module are:
  - To familiarize participants with the recommended guidelines for developing a successful therapeutic relationship with a client who has COD; and
  - To explore participants' perspectives on the consensus panel's *Advice to Counselors* guidelines.

Time management

- Time management is essential in this module, and use of a kitchen timer during the discussion exercise and report out can help keep both trainer and participants on track.

Seating

- The TIP Exercise discussion takes place early in the module using participant dyads or small groups of 3-5 participants. Should the trainer prefer participants work with someone other than the persons they are likely to sit with initially, this re-seating should be done quickly before the module begins, perhaps as part of an ice-breaker or warm-up activity.

Suggested Timetable for Module 5A

Introduction ■ Reconvening ■ In This Module	5 minutes
Introduction to *Guidelines for a Successful Therapeutic Relationship*	2 minutes
TIP Exercise—Advice to the Counselor ■ Assignment—*3 minutes* ■ Group Work—*8 minutes* ■ Report Out—*12 minutes*	23 minutes
Review of Guidelines for a *Successful Therapeutic Relationship* ■ Develop and Use a Therapeutic Alliance to Engage the Client in Treatment ■ Maintain a Recovery Perspective ■ Manage Countertransference ■ Monitor Psychiatric Symptoms ■ Use Supportive and Empathic Counseling ■ Employ Culturally Appropriate Methods – Cultural Differences and Treatment: Empirical Evidence on Effectiveness ■ Increase Structure and Support	10 minutes
Wrap up	5 minutes
TOTAL	**45 minutes**

5 minutes

OH #5A-1

Introduction

Reconvening

Trainer Note:

- Module 5A opens with a brief reference to the 12 Step assessment process covered in Modules 4A, 4B and 4C. This is intended to:
  - Re-emphasize the importance of client engagement and how essential the relationship between clinician and client is to engagement and positive outcomes
  - Recall content covered previously such as stages of change, psychiatric symptoms and diagnosis, and cultural issues, which are also addressed in Module 5A
- Check that everyone has a copy of the TIP. Lend copies or have people share.
- Review Module 4 sessions.

OH #5A-2

- During our last three (3) sessions, we reviewed the screening and assessment process. We spent significant time on each of the 12 Steps in the assessment process. The major goal of this complex process is to match the client with appropriate treatment, and that means treatment that takes into account the client's:
  - Mental health and substance abuse diagnoses
  - Needs related to trauma
  - Needed level of care
  - Needs related to disability and functional impairments
  - Cultural and linguistic needs
  - Difficulties in life domains
  - Current stage of change, and
  - Makes the best use of the client's strengths and supports

- Yet it probably came as no surprise that the first and one of the most important steps we discussed was to "engage the client" and the importance of the therapeutic relationship in the engagement process. Research tells us that "one of the most robust predictors of treatment outcome" in psychotherapy is the therapeutic alliance between the client and counselor (Najavits et al. 2000, p. 2172). This association between the strength of the therapeutic relationship and counseling effectiveness has also been shown to be true in the substance abuse treatment field.

In This Module . . .

OH #5A-3

- Chapter 5 in the TIP text addresses this vital relationship between client and counselor. Like the chapter, Module 5 is divided into two (2) parts.
  - Module 5A examines the guidelines for establishing and maintaining a successful therapeutic relationship with a client who has a COD.
  - Module 5B addresses specific strategies for working with clients with COD.

2 minutes

Introduction to *Guidelines for a Successful Therapeutic Relationship*

Trainer Note:

- This section begins exploration of the text and sets up the context for the TIP Exercise.
- Have participants turn to page 101.

- The chapter's very first sentence, on page 101 acknowledges that the therapeutic relationship can sometimes be a challenge, "Maintaining a therapeutic alliance with clients who have co-occurring disorders (COD) is important and difficult."
- The text then provides seven (7) guidelines that have been found to be particularly helpful in forming a therapeutic relationship with clients who have COD. Please turn to the text box at the bottom of page 102. *(Have participants turn to page 102. Wait until all have accessed the page.)*
- Our session today will focus on a review and discussion of these seven (7) guidelines and what they mean in practice:
  - Develop and use a therapeutic alliance to engage the client in treatment
  - Maintain a recovery perspective
  - Manage countertransference
  - Monitor psychiatric symptoms
  - Use supportive and empathic counseling
  - Employ culturally appropriate methods
  - Increase structure and support
- To make sure we have sufficient time for discussion, we will begin the module with a TIP Exercise that will give us a personal perspective on these guidelines. Then we will close the module with a brief review of the more general perspective provided by your text.

23 minutes

TIP Exercise—Advice to the Counselor

Trainer Note:

- The TIP exercise is an examination of the chapter's five (5) *Advice to the Counselor* text boxes (and the text box on page 109) by participant dyads or small groups. It is intended to facilitate understanding of what it means to apply the *Guidelines for a Successful Therapeutic Relationship* in practice.
- Having participants assess the importance of each piece of "advice" from the perspective of a client is a means of increasing participant receptivity to this material. It may also allow participants to view their personal practice from the most important point of view, that of their client.

3 minutes

Assignment

- There are five (5) *Advice to the Counselor* text boxes and one (1) regular text box in this chapter. Each is dedicated to one (1) of the guidelines. Only the last guideline has no text box.

Trainer Note:

- Assign one (1) of the following to each small group or dyad:
  - Guideline #1—Advice to the Counselor: Forming a therapeutic alliance (p. 103)
  - Guideline #2—Advice to the Counselor: Maintaining a recovery perspective (p. 105)
  - Guideline #3—Advice to the Counselor: Managing countertransference (p. 106)
  - Guideline #4—Advice to the Counselor: Monitoring psychiatric symptoms (p. 107)
  - Guideline #5—Using supportive and empathic counseling (p. 109)
  - Guideline #6—Advice to the Counselor: Using culturally appropriate methods (p. 111)
  - Guideline #7—(Does not include a text box of advice.)
- Assignments can be made by simply assigning the textbox and page to an individual group, or by writing the textbox titles and page numbers on slips of paper and allowing each group to pull an assignment slip out of a cup or a hat.
- If there are more than six (6) groups, the same textbox can be assigned to more than one (1) group. If there are less than six (6) groups, the trainer can quickly review the content of the unassigned textboxes during the latter part of the module or encourage participants to read it on their own.
- Participants will examine the recommendations in their advice text box from the perspective of a client with COD.

OH #5A-4

- Each group has been assigned (or has chosen) one (1) of these text boxes. During the next eight (8) minutes, you will focus on the "advice" from the TIP consensus panel regarding one (1) of the guidelines.
- As part of your review of the "advice," you and your partners are to:
  1. Imagine you are a person with COD receiving services.
  2. Review your assigned *Advice to the Counselor* text box.
  3. Decide which two (2) recommendations you would most want your provider to follow? Why?
- You will have eight (8) minutes. Be prepared to give a two (2)-minute report. You will read us all of the recommendations, tell us which two (2) your group chose, and explain from a client's perspective your group's reasons for the two (2) choices. Also, tell us about any discussion that went into making your choice.

8 minutes

Group Work

Trainer Note:

- Set timer for eight (8) minutes.
- During the discussion period, the trainer should move about the room to ensure that participants remain on task. Also, monitor that participants do not forget they are to assess the recommendations from the client's perspective and not their own perspective as counselors.
- Call time.

---

12 minutes

OH #5A-5

Report Out

Trainer Note:

- *Report Out / Peer-Teaching:* The group assigned with the advice text box corresponding to the first guideline reports first. If more than one (1) group was assigned the same guideline, have one (1) group report out and then ask the other group if they have anything to add.
- Each group will have two (2) minutes to:
  - State the guideline examined
  - Read aloud all of the recommendations
  - State which two (2) the group chose
  - Give reasons, from the client's perspective, for the group's choice and summarize any discussion that took place
- The trainer will want to establish a positive tone for this activity, introduce each group with a little flourish, and follow with applause after each presentation.

10 minutes

Review of *Guidelines for a Successful Therapeutic Relationship*

Trainer Note:

- In the time remaining after the TIP Exercise, the trainer will use the script to quickly review the guidelines from a more general perspective.
- Presentation of this section will need to be succinct, as only ten (10) minutes has been allotted to accommodate the TIP Exercise. More material than can be presented in ten (10) minutes is provided in the script. Facilitators will need to examine the script ahead of time and select the material that is of greatest need or interest to the group.
- Facilitators should emphasize that the module has been designed to familiarize participants with what is available in the TIP and as a context for discussion. It is not intended as a substitute for reading of the chapter.

- Now that we have examined the guidelines from a personal perspective, we will quickly review them from a more general perspective.
- There is a great deal of valuable information in the text. This module has been designed to familiarize you with what is available in the TIP and as a context for discussion. It is not intended as a substitute for reading of the chapter.

OH #5A-6

Guideline #1—Develop and Use a Therapeutic Alliance to Engage the Client in Treatment

- As mentioned earlier, the association between the therapeutic relationship and treatment outcomes has been demonstrated in several research studies. Some are included in the text.
  - For example, in a study of clients with opioid dependence and moderate to severe psychiatric problems fewer than 25 percent of those with weak therapeutic alliances completed treatment, while more than 75 percent of those with strong therapeutic alliances completed treatment (Petry and Bickel 1999).

Challenges for the clinician

- The clinician's ease in working toward a therapeutic alliance is affected by his or her comfort level in working with the client.
- Clinicians who experience difficulty forming a therapeutic alliance with clients with COD are advised to consider whether this is related to:
  - The client's difficulties
  - A limitation in the clinician's own experience and skills
  - Demographic differences between the clinician and the client in areas such as age, gender, education, race, or ethnicity
  - Issues involving countertransference
- Individuals with COD often experience demoralization and despair because of the complexity of having two (2) problems and the difficulty of achieving treatment success. Inspiring hope often is a necessary precursor for the client to give up short-term relief in exchange for long-term work with some uncertainty as to timeframe and benefit.
- Nevertheless, clients with COD often need the therapeutic alliance to foster not only their engagement in treatment but as the cornerstone of the entire recovery process.

OH #5A-7

Guideline #2—Maintain a Recovery Perspective

- ***ASK***—Think about how you would answer the question "What is recovery?"
- The word "recovery" has different meanings in different contexts, including the substance abuse and mental health treatment fields and 12-Step programs. On page 104 at the top of the right column is our working definition for recovery:
  - While 'recovery' has many meanings, generally, it is recognized that recovery does not refer solely to a change in substance use, but also to a change in an unhealthy way of living.
  - Markers such as improved health, better ability to care for oneself and others, a higher degree of independence, and enhanced self-worth are all indicators of progress in the recovery process.

Implications of the recovery perspective

- The two (2) main features of the recovery perspective are that it:
  - Acknowledges that recovery is a long-term process of internal change
  - Recognizes that these internal changes proceed through various stages (See De Leon 1996 and Prochaska et al. 1992 for a detailed description.)
- The rest of this section in the text examines the implications of this perspective. For example, a recovery perspective generates at least two (2) main principles for practice. These are listed on page 104 in bold italics:
  - First, develop a treatment plan that provides for continuity of care over time.
  - Second, devise treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process.
    - Markers that are unique to individuals should be considered, so it is important to engage the client in defining markers of progress that are meaningful to him and to each stage of recovery.
- Other essential aspects of the recovery perspective include:

SOC

  - The expectation that the client's progress through treatment stages be consistent with the client's stage of change
  - Emphasis on the empowerment and responsibility of the client and the client's network of family and significant others
  - The need for continuing support for recovery
  - An emphasis on continuity of treatment

Guideline #3—Manage Countertransference

OH #5A-8

- Guideline #3 addresses the concept of "countertransference." Please turn to page 316 of your text's glossary for our working definition.

Trainer Note:

- Allow participants to access page 316. Read definition from the text.

- Countertransference is described as, "the feelings, reactions, biases, and images from the past that the clinician may project onto the client with COD."
  - The clinician's negative attitudes or beliefs may be communicated, directly or subtly, to the client.
- Countertransference issues are particularly important when working with persons with COD because many people with substance abuse and mental disorders may evoke strong feelings in the clinician that could become barriers to treatment if the provider allows them to interfere.
- For example, both substance use disorders and mental disorders are illnesses that are stigmatized by the general public. These same attitudes can be present among clinicians.
- Cultural issues also may arouse strong and often unspoken feelings and, therefore, generate transference and countertransference. Although counselors working with clients in their area of expertise may be familiar with countertransference issues, working with an unfamiliar population will introduce different kinds and combinations of feelings.
- The clinician is advised to understand and be familiar with some of the issues related to countertransference and strategies to manage it.

Guideline #4—Monitor Psychiatric Symptoms

OH #5A-9

- It is important for the substance abuse counselor to participate in the development of the treatment plan. At a minimum, the clinician should be knowledgeable about the overall treatment plan to permit reinforcement of the mental health part of the plan as well as the part specific to recovery from addiction.

Status of symptoms

- Most clients present for substance abuse treatment with some degree of anxiety or depressive symptoms. Substance abuse counselors need to have a consistent method by which to monitor changes in severity and number of symptoms over time.
  - To identify changes, it is important for the counselor to track symptoms that the client mentions at the onset of treatment from week to week.
- Adherence to prescribed medications also should be monitored by asking the client regularly for information about its use and effects.
  - As discussed previously, starting on page 463 in Appendix F you will find a primer titled *Psychotherapeutic Medications: What Every Counselor Should Know*. This appendix includes tips for talking with clients about medication, specific information on a wide variety of medications, and tips for communicating effectively with physicians.

Potential for harm to self or others

- This topic of monitoring psychiatric symptoms and medications is particularly important because suicidality is a major concern for many clients with COD.
  - Clients with COD—especially those with affective disorders—have two (2) of the highest risk factors for suicide.

OH #5A-10

- The clinician always should ***ask explicitly*** about suicide or the intention to do harm to someone else when the client assessment indicates that either is an issue.
- With clients who mention or appear to be experiencing depression or sadness, explore the extent to which suicidal thinking is present. Similarly, a client who reports that he or she is thinking of doing harm to someone else must be monitored closely.
- Asking the client about suicidal thoughts and plans should be a routine part of every session with a suicidal or depressed person.
- *Immediately follow up appointments missed by an acutely suicidal person.*
- For more detailed information on this important topic, take advantage of the resources in your TIP text, including the extensive discussion of suicidality in Chapter 8 and in Appendix D, starting on page 326.

Guideline #5—Use Supportive and Empathic Counseling

OH #5A-11

- Use of a supportive and empathetic style of counseling is essential to the therapeutic alliance. Support and empathy on the clinician's part can help clients:
  - Begin to recognize and own their own feelings
  - Manage their own feelings
  - Learn to empathize with the feelings of others
- A critical caveat for clients with COD is that this type of counseling must be used *consistently over time* to keep the alliance intact.

Confrontation and empathy

- However, as discussed in this section of the text, an empathic style does not necessarily preclude confrontation.

OH #5A-12

- On page 110, the text makes the case that interactions can be both firm and empathic when working with clients with COD because:
  - The heart of confrontation is not the aggressive breaking down of the client and his or her defenses, but feedback on behavior and the compelling appeal to the client for personal honesty, truthfulness in interacting with others, and responsible behavior.
- The ability to do this well and with balance often is critical in maintaining the therapeutic alliance with a client who has COD. Chapter 6 (p. 169) contains a more complete discussion of confrontation including a definition, description of its application, and suggested modifications for using this technique with clients who have COD.

CC

OH #5A-13

Guideline #6—Employ Culturally Appropriate Methods

- As we have discussed previously, cultural issues can sometimes create misunderstandings and impede development of an effective therapeutic alliance.
- Providers are advised to learn as much as possible about the cultures represented in their treatment populations. Of particular importance are those discussed beginning on page 110, bottom left hand column:
  - The backgrounds of those served
  - Their conventions of interpersonal communication
  - Their understanding of healing
  - Their views of mental disorder, and
  - Their perception of substance abuse

Clients' perceptions of substance abuse, mental disorders, and healing

- Clients may have culturally driven concepts of what it means to abuse substances or to have a mental disorder, what causes these disorders, and how they may be "cured." Wherever appropriate, familiar healing practices meaningful to these clients should be integrated into treatment.
- However, a clinician must be careful not make assumptions regarding an individual client based on what the clinician knows about a cultural group. Always verify with that individual. A client's level of acculturation and specific experiences may result in identification with the dominant culture, or even other cultures.

Cultural perceptions and diagnosis

- It is also important to be aware of cultural and ethnic bias in diagnosis of disorders. For example, in the past:
  - African Americans have been stereotyped as having paranoid personality disorders.
  - Women have been diagnosed frequently as being histrionic.
  - American Indians with spiritual visions have been misdiagnosed as delusional or as having borderline or schizotypal personality disorders.
  - Even today, some clinicians might be likely to over diagnose obsessive-compulsive disorder among Germans or histrionic disorder in Hispanic/Latino populations.
- The diagnostic criteria should be tempered by sensitivity to cultural differences in behavior and emotional expression and by an *awareness of the clinician's own biases and stereotyping*.

Cultural Differences and Treatment: Empirical Evidence on Effectiveness

Trainer Note:

- If time allows, ask participants turn to page 111.
- Highlight for participants that evidence derived from research studies suggests that issues related to developing cultural competence deserve providers' attention.

- Studies related to cultural differences and treatment issues among clients with COD are scarce.
- However, one study that compared both nonwhite and white clients with COD who were treated in mental health settings found that African-American, Asian American, and Hispanic/Latino clients tended to self-report a lower level of functioning and to be "viewed by clinical staff as suffering from more severe and persistent symptomalogy and as having lower psychosocial functioning" (Jerrell and Wilson 1997, p. 138).
- Researchers noted "this was due in part to the chronicity of their mental disorders and persistent substance abuse, but also was magnified by cross-cultural misperceptions" (Jerrell and Wilson 1997, p. 138).
- The study also found that nonwhite clients tended to have fewer community resources than white clients, and that clinicians had more difficulty connecting them with needed resources.

OH #5A-14

Guideline #7—Increase Structure and Support

- To assist clients with COD, counselors should provide an optimal amount of structure for the individual.
  - Free time is both a trigger for substance use cravings and a negative influence for many individuals with mental disorders. Therefore, it is a particular issue for clients with COD.
- Strategies for managing free time include structuring one's day to have meaningful activities and to avoid activities that will be risky.
  - Other important activities to include are working on vocational and relationship issues.
- In addition to structure, it is also important that the daily activities contain opportunities for receiving support and encouragement.
  - Counselors should work with clients to create a healthy support system of friends, family, and activities.

5 minutes

Wrap up

Trainer Note:

- The facilitator wraps up the session by reiterating the importance of the therapeutic relationship, especially for persons with COD.
- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

- We have talked about the seven (7) guidelines for developing and maintaining successful therapeutic alliances with clients with COD. These are not easy tasks. In the case of clients with COD, however, research has shown how powerful the therapeutic alliance can be with regard to recovery. Our clients often need the therapeutic alliance to foster not only their engagement in treatment but as the cornerstone of the entire recovery process.

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 5A

Introduction

Strategies for Working with Clients with Co-Occurring Disorders: *Guidelines for a Successful Therapeutic Alliance*

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

12 Step Assessment Process

1. Engage the client
2. Identify & contact collaterals to gather additional information
3. **Screen for & detect COD**
4. Determine quadrant & locus of responsibility
5. Determine level of care
6. Determine diagnosis
7. Determine disability & functional impairment
8. Identify strengths & supports
9. Identify cultural & linguistic needs & supports
10. Identify problem domains
11. Determine stage of change
12. Plan treatment

In This Module . . .

- **Module 5A**
  - Review guidelines for maintaining a successful therapeutic relationship with a client who has COD
- Module 5B
  - Examine techniques for working with clients with COD

TIP Exercise—
Advice to the Counselor

With your partner(s):

1. Imagine you are a person with COD receiving services.
2. Review your assigned *Advice to the Counselor* text box.
3. Which two (2) recommendations would you most want your provider to follow? Why?

(8 minutes)

TIP Exercise—Report Out

- State the Guideline you examined.
- Read aloud all of the recommendations.
- State which two (2) your group chose.
- Give reasons for your group's choice and summarize any discussion that took place.

(2 minutes)

Guidelines for Developing Successful Therapeutic Relationships

1. **Develop and use a therapeutic alliance to engage the client in treatment**
2. Maintain a recovery perspective
3. Manage countertransference
4. Monitor psychiatric symptoms
5. Use supportive and empathic counseling
6. Employ culturally appropriate methods
7. Increase structure and support

Guidelines for Developing Successful Therapeutic Relationships

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2. Maintain a recovery perspective
3. Manage countertransference
4. **Monitor psychiatric symptoms**
5. Use supportive and empathic counseling
6. Employ culturally appropriate methods
7. Increase structure and support

Potential for Harm

- Ask ***explicitly*** about suicide or the intention to do harm to someone else when the client assessment indicates that either is an issue.
- Monitor clients who express such thoughts closely.
- Ask about suicidal thoughts and plans as a routine part of every session with a suicidal or depressed person.
- ***Immediately*** follow up appointments missed by an acutely suicidal person.
- Review discussion of suicidality in Chapter 8 and in Appendix D of TIP 42.

Guidelines for Developing Successful Therapeutic Relationships

1. Develop and use a therapeutic alliance to engage the client in treatment
2. Maintain a recovery perspective
3. Manage countertransference
4. Monitor psychiatric symptoms
5. **Use supportive and empathic counseling**
6. Employ culturally appropriate methods
7. Increase structure and support

Confrontation

"The heart of confrontation is not the aggressive breaking down of the client and his or her defenses, but feedback on behavior and the compelling appeal to the client for personal honesty, truthfulness in interacting with others, and responsible behavior."

TIP 42, p. 110

Guidelines for Developing Successful Therapeutic Relationships

1. Develop and use a therapeutic alliance to engage the client in treatment
2. Maintain a recovery perspective
3. Manage countertransference
4. Monitor psychiatric symptoms
5. Use supportive and empathic counseling
6. **Employ culturally appropriate methods**
7. Increase structure and support

Guidelines for Developing Successful Therapeutic Relationships

1. Develop and use a therapeutic alliance to engage the client in treatment
2. Maintain a recovery perspective
3. Manage countertransference
4. Monitor psychiatric symptoms
5. Use supportive and empathic counseling
6. Employ culturally appropriate methods
7. **Increase structure and support**

MODULE 5B: Strategies for Working with Clients with Co-Occurring Disorders: Techniques for Working with Clients with COD

Objectives

- Chapter 5 in the TIP text is divided into two (2) sections: a section providing guidelines for building successful therapeutic relationships, and a section outlining specific techniques that are effective in counseling clients with COD. Module 5 has therefore been divided into two (2) 45-minute sessions:
  - Module 5A reviews the guidelines for maintaining a successful therapeutic relationship with a client who has COD.
  - ***Module 5B*** examines techniques for working with clients with COD.
  - Included in these modules is discussion of text content, a focus on the *Advice to Counselors* text boxes, and references to the relevant appendices in the TIP text.

Trainer Note:

- The following sections refer to Module 5B only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 5B.1-5B.10
- Markers and Post-It Notes for participants to use on their TIP texts

Module Design

- This module is primarily lecture and participant interaction with the text. It reviews techniques, mainly from the substance abuse field, that have been found to be particularly helpful in the treatment of clients with substance abuse and that are being adapted for work with clients with COD. It also illustrates application to practice using case studies from the TIP 42 text. The techniques include:

  1. Provide motivational enhancement consistent with the client's specific stage of change.
  2. Design contingency management techniques to address specific target behaviors.
  3. Use cognitive-behavioral therapeutic techniques.
  4. Use relapse prevention techniques.
  5. Use repetition and skills-building to address deficits in functioning.
  6. Facilitate client participation in mutual self-help groups.

- The module addresses each of the six (6) techniques as fully as possible given the time available. However, participant groups are likely to have more experience with some of these models and techniques and less so with others. The facilitator should therefore adapt the length and detail of each presentation topic area to match the needs of the group, devoting more time (and perhaps some minimal discussion) to those areas least familiar or of greatest interest to participants.

Presentation and Case Studies

- Presentation for each of the six (6) techniques closely follows the organization of Chapter 5, constantly referring to the actual text. Facilitators must become familiar beforehand with Chapter 5 and the sections of it used in this module in order to effectively use the text and guide participants during the presentation.
- In case the facilitator is not familiar with the participants and their level of knowledge with the key techniques, a question is built into the script at the beginning of each topic area that solicits this information. This allows the trainer to adjust the level of detail to the needs of the group. It will also identify "experts" among the participants who can be called on to provide practical examples of the techniques discussed.
- If the trainer is familiar with the trainees and their practice, then he or she may wish to delete sections that are redundant. Time gained can be used to discuss participants' reactions to the case studies.
- Each presentation begins with a brief description of the topic, provides additional context and then demonstrates application using the case study. Facilitators will either read the case study aloud or ask participants to take turns reading to the group. However, facilitators should be familiar enough with each case should time limitations require them to merely summarize the main points of the case.
- The case study for the section on repetition and skills-building has been omitted due to time considerations. The facilitator may wish to include it should time permit.
- The text for case studies used in this training is included in the module's script should the facilitator prefer to read from the training manual.

Suggested Timetable for Module 5B	
Introduction ■ Reconvening ■ In This Module ■ Key Techniques for Working with Clients with COD	2 minutes
Motivational Enhancement Techniques ■ Introduction to Case Study	10 minutes
Contingency Management Techniques ■ Introduction to Case Study ■ Empirical Evidence on the Effectiveness of Contingency Management	8 minutes
Cognitive—Behavioral Therapeutic Techniques ■ Introduction to Case Study	8 minutes
Relapse Prevention Techniques ■ Introduction to Case Study ■ Substance Abuse Management Module (SAMM)	8 minutes
Repetition and Skills—Building to Address Deficits in Functioning	2 minutes
Facilitate Client Participation in Mutual Self-Help Groups ■ Introduction to Case Study	5 minutes
Wrap up	2 minutes
TOTAL	**45 minutes**

2 minutes

OH #5B-1

Introduction

Reconvening

Trainer Note:

- Although this set-up is very brief, it emphasizes that the session can only touch on each of the techniques and related case studies. The session is not intended as a substitute for reading the chapter.
- Because of the heavy interaction with the text, the facilitator must make sure all participants have access to a TIP 42 text. Lend copies or have people share.

- Our last session introduced Module 5 and focused on the therapeutic relationship between the counselor and the client with a COD. In Module 5A we examined guidelines for establishing and maintaining a successful therapeutic relationship with a client who has COD.

In This Module . . .

OH #5B-2

- Module 5B focuses on the second part of Chapter 5. It reviews techniques, mainly from the substance abuse field, that have been found to be particularly helpful in the treatment of clients with substance abuse and that are being adapted for work with clients with COD.

Key Techniques for Working with Clients with COD

- Please turn to the text box at the bottom of page 112. *(Allow participants to access page 112.)*
- The techniques we will discuss in this module are listed in the text box titled *Key Techniques for Working with Clients Who Have COD:*
  - Provide motivational enhancement consistent with the client's specific stage of change
  - Design contingency management techniques to address specific target behaviors
  - Use cognitive-behavioral therapeutic techniques
  - Use relapse prevention techniques
  - Use repetition and skills-building to address deficits in functioning
  - Facilitate client participation in mutual self-help groups
- Some of these techniques are complex treatment models with an extensive literature base. Your text offers a look at some of the empirical evidence for each technique as well as adaptations for clients with COD.
- There is a great deal of material in this section of the text. During this session we will briefly touch on each of the techniques and examine related case studies. This session, however, will merely give you a taste of each and familiarize you with some of the resources available to you in the text. For more extensive information, you are encouraged to read the complete text and explore some of the references mentioned.

10 minutes

MI

SOC

OH #5B-3

OH #5B-4

Motivational Enhancement Techniques

Trainer Note:

- If the trainer is not familiar with participants:
- ***ASK***—How familiar are you with Motivational Interviewing (MI)? How do you use it in your program?
- Adjust detail of presentation to response (or to participant's knowledge of the topic based on trainer's familiarity with participants).
- Have those with more expertise provide concrete illustrations for novices.

Definition and description

- Motivational Interviewing (MI) has been defined in your text as a "client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller and Rollnick 2002, p. 25). Each of these words is important.
  - MI is *client centered*—it assumes that, with some help, the client is in the best position to resolve his or her problems.
  - MI is a *directive method* and its goal is to *enhance the motivation to change that exists in the client*. This approach involves accepting a client's level of motivation, whatever it is, as the only possible starting point for change.
  - MI enhances the client's motivation to change by *exploring and resolving ambivalence*.
  - MI is one of the first two (2) psychosocial treatments being sponsored in multisite trials in the National Institute on Drug Abuse (NIDA) Clinical Trials Network program.
- There are four (4) guiding principles of Motivational Interviewing. These are summarized in the text box on page 114. Please turn to page 114. *(Allow participants to access page 114.)*

Trainer Note:

- Review the grid briefly using the grid's text or the script provided below the chart.

Guiding Principles of Motivational Interviewing	
1. Express empathy	■ Acceptance facilitates change. ■ Skillful reflective listening is fundamental. ■ Ambivalence is normal.
2. Develop discrepancy	■ The client rather than the counselor should present the arguments for change. ■ Change is motivated by a perceived discrepancy between present behavior and important personal goals or values.
3. Roll with resistance	■ Avoid arguing for change. ■ Resistance is not opposed directly. ■ New perspectives are invited but not imposed. ■ The client is a primary resource in finding answers and solutions. ■ Resistance is a signal to respond differently.
4. Support self-efficacy	■ A person's belief in the possibility of change is an important motivator. ■ The client, not the counselor, is responsible for choosing and carrying out change. ■ The counselor's own belief in the person's ability to change becomes a self-fulfilling prophecy.

TIP 42, p. 114

- *Express empathy*
  - In Motivational Interviewing, the counselor refrains from judging the client. Instead, the counselor projects an attitude of acceptance, that the individual's ambivalence to change is normal.
  - This acceptance of the client's perspectives does not imply agreement. Instead, practitioners find that projecting acceptance rather than censure helps free the client to change (Miller and Rollnick 2002).
- *Develop discrepancies*
  - The counselor advances the cause of change not by insisting on it, but by helping the client perceive the discrepancy between the current situation and the client's personal goals (such as a supportive family, successful employment, and good health).
  - The client is therefore more likely to change, because he sees that the current behavior is impeding progress to *his* goals-not the counselor's (Miller and Rollnick 2002).
- *Roll with resistance*
  - "The least desirable situation, from the standpoint of evoking change, is for the counselor to advocate for change while the client argues against it" (Miller and Rollnick 2002, p. 39). The desired situation is for the client to make the argument for change.
  - Therefore, the counselor does not oppose resistance outright. Instead, the counselor offers new information and alternative perspectives, giving the client respectful permission to "take what you want and leave the rest" (Miller and Rollnick 2002, p. 40).
- *Support self-efficacy*
  - The final principle of Motivational Interviewing recognizes that an individual must believe he or she actually can make a change before attempting to do so. Therefore, the counselor offers support for the change and communicates to the client a strong sense that change is possible.

Matching motivational strategies to the client's stage of change

- An important aspect of MI is that the motivational strategies selected should be consistent with the client's stage of change. We have discussed the stages of change previously and a summary chart of these stages is available on page 116. *(Allow participants to access page 116.)*
- As we have discussed previously, clients with COD may be at one stage for the mental disorder and another for the substance use disorder.
  - The counselor will want to select an approach that matches the client's stage of change regarding the problem being addressed.
- On page 117, Figure 5-2 illustrates approaches that a clinician might use to apply MI techniques when working with a substance abuse client showing evidence of COD. These are organized to correspond to the different stages of readiness to change.

Trainer Note:

- Allow participants to access page 117.
- Refer to the text. For each stage of change, read one (1) example of an approach (e.g., one of the suggested approaches at the precontemplation stage is to "explore the client's perception of a substance use or psychiatric problem." Then, at the contemplation stage, you might want to "elicit positive and negative aspects of substance use or psychological symptoms.")

Introduction to Case Study

- Now let's look at a case study and see how MI would work in practice. Please turn to page 121. *(Allow participants to access page 121.)*
- As we read over the case of Gloria M., keep in mind the four (4) principles of empathy, developing discrepancy, rolling with resistance and supporting self-efficacy.

Trainer Note:

- Trainer reads case aloud (see script below or read from text), or have participants take turns reading sections out loud.

Case Study: Using MET with a Client Who Has COD, p. 121

Gloria M. is a 34-year-old African-American female with a 10-year history of alcohol dependence and 12-year history of bipolar disorder. She has been hospitalized previously both for her mental disorder and for substance abuse treatment. She has been referred to the outpatient substance abuse treatment provider from inpatient substance abuse treatment services after a severe alcohol relapse.

Over the years, she sometimes has denied the seriousness of both her addiction and mental disorders. Currently, she is psychiatrically stable and is prescribed valproic acid to control the bipolar disorder. She has been sober for 1 month.

At her first meeting with Gloria M., the substance abuse treatment counselor senses that she is not sure where to focus her recovery efforts—on her mental disorders or her addiction. Both have led to hospitalization and to many life problems in the past. Using motivational strategies, the counselor first attempts to find out Gloria M.'s own evaluation of the severity of each disorder and its consequences to determine her stage of change in regard to each one.

Gloria M. reveals that while in complete acceptance and an active stage of change around alcohol dependence, she is starting to believe that if she just goes to enough recovery meetings she will not need her bipolar medication. Noting her ambivalence, the counselor gently explores whether medications have been stopped in the past and, if so, what the consequences have been. Gloria M. recalls that she stopped taking medications on at least half a dozen occasions over the last 10 years. Usually, this led her to jail, the emergency room, or a period of psychiatric hospitalization. The counselor explores these times, asking: Were you feeling then as you were now-that you could get along? How did that work out? Gloria M. remembers believing that if she attended 12-Step meetings and prayed she would not be sick. In response to the counselor's questions, she observes, "I guess it hasn't ever really worked in the past."

The counselor then works with Gloria M. to identify the best strategies she has used for dual recovery in the past. "Has there been a time you really got stable with both disorders?" Gloria M. recalls a 3-year period between the ages of 25 and 28 when she was stable, even holding a job as a waitress for most of that period. During that time, she recalls, she saw a psychiatrist at a local mental health center, took medications regularly, and attended AA meetings frequently. She recalls her sponsor as being supportive and helpful. The counselor then affirms the importance of this period of success and helps Gloria M. plan ways to use the strategies that have already worked for her to maintain recovery in the present.

8 minutes

OH #5B-5

Contingency Management Techniques

- Next, we will examine contingency management techniques.

Trainer Note:

- If the trainer is not familiar with participants:
- ***ASK***—How familiar are you with contingency management techniques? How do you use these in your program?
- Adjust detail of presentation to response (or to participant's knowledge of the topic based on trainer's familiarity with participants).
- Have those with more expertise provide concrete illustrations for novices.

Introduction to Case Study

- We will start by meeting the case study client. Please turn to the case study on page 124. *(Allow participants to access page 124.)*

Trainer Note:

- Read only the "Initial Assessment" section of the case study (see below) or have a participant read it aloud.

Case Study: Using Contingency Management with a Client with COD, p. 124

Initial Assessment

Mary A. is a 45-year-old Caucasian woman diagnosed with heroin and cocaine dependence, depression, antisocial personality disorder, and cocaine-induced psychotic episodes. She has a long history of prostitution and sharing injection equipment. She contracted HIV 5 years ago.

Mary A. had been on a regimen of methadone maintenance for about 2 years. Despite dose increases up to 120 mg/day, she continued using heroin at the rate of 1 to 15 bags per day as well as up to 3 to 4 dime bags per day of cocaine. After cessation of a cocaine run, Mary A. experienced tactile and visual hallucinations characterized by "bugs crawling around in my skin." She mutilated herself during severe episodes and brought in some of the removed skin to show the "bugs" to her therapist.

Mary A. had been hospitalized four times for cocaine-induced psychotic episodes. Following an 11-day stay in an inpatient dual diagnosis program subsequent to another cocaine-induced psychotic episode, Mary A. was referred to an ongoing study of contingency management interventions for methadone-maintained, cocaine-dependent outpatients.

- Mary's service providers would like to use Contingency Management techniques to try to help.

Description of Contingency Management

- ***ASK***—So, what is contingency management?
- Please turn to page 121. We will come back to Mary's case in a few minutes. *(Allow participants to access page 121.)*
- On the right column of page 121 is a description of contingency management.
  - Contingency management (CM) maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences.
- Many counselors and programs employ CM principles informally when they praise or reward particular behaviors and accomplishments. Even formal use of CM principles is found in programs where attainment of certain levels and privileges are contingent on meeting certain behavioral criteria.
- On page 123 is a *Checklist for Designing Contingency Management (CM) Programs*. Please turn to page 123. *(Allow participants to access page 123.)*

Trainer Note:

- Briefly go over the following checklist.

Figure 5-4
Checklist for Designing CM Programs

Step	Description
1. Choose a behavior	■ One that is objectively quantifiable, occurs frequently, and is considered to be most important. ■ Set reasonable expectations.
2. Choose a reinforcer	■ Determine available resources (in-house rewards or donations of cash or services from local businesses such as movie theaters and restaurants). ■ Identify intangible rewards, such as frequent positive reports to parole officers, flexibility in methadone dosing, and increased freedom (smoke breaks, passes, etc.).
3. Use behavioral principles	■ Develop a monitoring and reinforcement schedule that is optimized through application of behavioral principles. ■ Keep the schedule simple so staff can apply principles consistently and clients can understand what is expected.
4. Prepare a behavioral contract	■ Draw up a contract for the target behavior that considers the monitoring system and reinforcement schedule. ■ Be specific and consider alternate interpretations; have others review the contract and comment. ■ Include any time limitations.
5. Implement the contract	■ Ensure consistent application of the contract; devise methods of seeing that staff understands and follows procedures. ■ Remind the client of behaviors and their consequences (their "account balance" and what is required to obtain a bonus) to increase the probability that the escalating reward system will have the desired effect.

Source: Petry 2000*a*.

- Now, let's see what this would look like in practice. Please turn to page 124 and we will continue with our case study. *(Allow participants to access page 124.)*

Trainer Note:

- Read the remainder of the case study aloud, starting with the "Behaviors to Target" section (read from TIP text or from the script below) or have individual participants read the sections aloud.

Case Study: Using CM with a Client with COD, p. 124—continued

Behaviors to Target

Mary A.'s primary problem was her drug use, which was associated with cocaine-induced psychosis and an inability to adhere to a regimen of psychiatric medications and methadone. Because her opioid and cocaine use were linked intricately, it was thought that a CM intervention that targeted abstinence from both drugs would improve her functioning. As she was already maintained on a high methadone dose, methadone dose adjustments were not made.

CM Plan

Following discharge from the psychiatric unit, Mary A. was offered participation in a NIDA-funded study evaluating lower-cost contingency management treatment (e.g., Petry et al. 2000, pp. 250-257) for cocaine-abusing methadone clients. As part of participation in this study, Mary A. agreed to submit staff-observed urine samples on 2 to 3 randomly selected days each week for 12 weeks. She was told that she had a 50 percent chance of receiving standard methadone treatment plus frequent urine sample testing of standard treatment along with a contingency management intervention. She provided written informed consent, as approved by the University's Institutional Review Board.

Mary A. was assigned randomly to the CM condition. In this condition, she earned one draw from a bowl for every urine specimen that she submitted that was clean from cocaine or opioids and four draws for every specimen that was clean from both substances. The bowl contained 250 slips of paper. Half of them said "Good job" but did not result in a prize. Other slips stated "small prize" (N=109), "large prize" (N=15), or "jumbo prize" (N=1). Slips were replaced after each drawing so that probabilities remained constant. A lockable prize cabinet was kept onsite in which a variety of small prizes (e.g., socks, lipstick, nail polish, bus tokens, $1 gift certificates to local fast-food restaurants, and food items), large prizes (sweatshirts, portable CD players, watches, and gift certificates to book and record stores), and jumbo prizes (VCRs, televisions, and boom boxes) were kept. When a prize slip was drawn, Mary A. could choose from items available in that category. All prizes were purchased through funds from the research grant.

In addition to the draws from the bowl for clean urine specimens, for each week of consecutive abstinence from both cocaine and opioids Mary A. earned bonus draws. The first week of consecutive cocaine and opioid abstinence resulted in five bonus draws, the second week resulted in six bonus draws, the third week seven and so on. In total, Mary A. could earn about 200 draws if she maintained abstinence throughout the 12-week study.

Clinical Course

Mary A. earned 175 draws during treatment, receiving prizes purchased for a total of $309. She never missed a day of methadone treatment, attended group sessions regularly, and honored all her individual counseling sessions at the clinic. At 6-month follow-up, she had experienced only one drug use lapse, which she self-reported. Her depression cleared with her abstinence, and so did her antisocial behavior. She was pleased with the prizes and stated, "Having good stuff in my apartment and new clothes makes me feel better about myself. When I feel good about me, I don't want to use cocaine." *Source:* Adapted from Petry et al. 2001*b*.

Empirical Evidence on the Effectiveness of Contingency Management

Trainer Note:

- Ask participants to access page 122.
- Highlight evidence derived from research studies on CM. Refer participants to the source citations in the TIP text.
- Instruct participants to access the full citations for the studies in Appendix A as a way to familiarize participants with this valuable resource provided in the TIP.
- Encourage participants to look through the bibliography on their own time and to take advantage of it in the future as a ready resource for research studies related to COD.
- Resume lecture.

- A substantial empirical base supports CM techniques, which have been applied effectively to a variety of behaviors.
- CM techniques have demonstrated effectiveness in enhancing treatment retention and confronting drug use (e.g., Higgins 1999; Petry et al. 2000). The techniques have been shown to address use of a variety of specific substances, including opioids (e.g., Higgins et al. 1986; Magura et al. 1998), marijuana (Budney et al. 1991), alcohol (e.g., Petry et al. 2000), and a variety of other drugs including cocaine (Budney and Higgins 1998).
- The use of vouchers and other reinforcers has considerable empirical support (e.g., Higgins 1999; Silverman et al. 2001), but little evidence is apparent for the relative efficacy of different reinforcers.
- The effectiveness of CM principles when applied in community-based treatment settings and specifically with clients who have COD remains to be demonstrated.

8 minutes

OH #5B-6

Cognitive—Behavioral Therapeutic Techniques

- The techniques we will examine next are cognitive-behavioral therapeutic techniques. This section starts on page 125. *(Allow participants to access page 125.)*

Trainer Note:

- If the trainer is not familiar with participants:
- ***ASK***—How familiar are you with cognitive-behavioral therapy? How do you use it in your practice?
- Adjust detail of presentation to response (or to participant's knowledge of the topic based on trainer's familiarity with participants).
- Have those with more expertise provide concrete illustrations for novices.

Description of Cognitive—Behavioral Therapy

- Cognitive-behavioral therapy (CBT) is a therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. CBT is aimed at both thought and behavior change—i.e., coping by thinking differently and coping by acting differently.

One cognitive technique is known as "cognitive restructuring." For example, a client may think initially, "The only time I feel comfortable is when I'm high," and learn through the counseling process to think instead, "It's hard to learn to be comfortable socially without doing drugs, but people do so all the time" (TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse* [CSAT 1999*a*], pp. 64-65).

- CBT includes a focus on overt, observable behaviors-such as the act of taking a drug—and identifies steps to avoid situations that lead to drug taking.
  - CBT for substance abuse helps clients recognize situations where they are likely to use substances, find ways of avoiding those situations, and learn better ways to cope with feelings and situations that might have, in the past, led to substance use (Carroll 1998).

- An underlying assumption of CBT is that the client systematically and negatively distorts her view of the self, the environment, and the future (O'Connell 1998). Therefore, a major tenet of CBT is that the person's thinking is the source of difficulty and that this distorted thinking creates behavioral problems.
  - Distortions in thinking generally are more severe with people with COD. For example, a person with depression and an alcohol use disorder who has had a bad reaction to a particular antidepressant may claim that all antidepressant medication is bad and must be avoided at all costs.
  - Likewise, individuals may use magnification and minimization to exaggerate the qualities of others, consistently presenting themselves as "losers" who are incapable of accomplishing anything.
- CBT approaches use cognitive and/or behavioral strategies to identify and replace irrational beliefs with rational beliefs. At the same time, the approach prescribes new behaviors the client practices.

Introduction to Case Study

- Let's explore what it might look like to use cognitive-behavioral therapy techniques in practice with a client who has COD. Please turn to page 127. *(Allow participants to access page 127.)*

Trainer Note:

- Ask participants to take turns reading the case aloud, or the trainer can read aloud (from the text or from the script below).

Case Study: Using CBT with a Client with COD, p. 127

Jack W. is referred to the substance abuse treatment agency for evaluation after a positive urine test that revealed the presence of cocaine. He is a 38-year-old African American. Initially, Jack W. engages in treatment in intensive outpatient therapy three times weekly, has clean urine tests, and seems to be doing well. However, after two months he starts to appear more depressed, has less to say in group therapy sessions, and appears withdrawn. In a private session with the substance abuse treatment counselor, he says that, "All this effort just isn't worth it. I feel worse than I did when I started. I might as well quit treatment and forget the job. What's the point?" The counselor explores what has changed, and Jack W. reveals that his wife has been having a hard time interacting with him as a sober person. Now that he is around the house more than he used to be (he was away frequently, dealing drugs to support his habit), they have more arguments. He feels defeated.

In the vocabulary of CBT, Jack W. demonstrates all or nothing thinking (I might as well lose everything because I'm having arguments), overgeneralization, and discounting the positive (he is ignoring the fact that he still has his job, has been clean for two months, looks healthier and, until recently, had an improved outlook). His emotionally clouded reasoning is blackening the whole recovery effort, as he personalizes the blame for what he sees as failure to improve his life.

Clearly, Jack W. has lost perspective and seems lost in an apparently overwhelming marital problem. The counselor, using a pad and pencil, draws a circle representing the client and divides it into parts, showing Jack that they represent physical health, his work life, his recovery, risk for legal problems, and family or marriage. He invites Jack to review each one, comparing where he is now and where he was when he first arrived at the clinic in order to evaluate the whole picture. Jack observes that everything is actually getting better with the exception of his marriage. The counselor helps Jack gain the skills needed to stand back from his situation and put a problem in perspective. He also negotiates to determine the kind of help that Jack would see as useful in his marriage. This might be counseling for the couple or an opportunity to practice and rehearse ways of engaging his wife without either of them becoming enraged.

If Jack's depression continues despite these interventions, the counselor may refer him to a mental health provider for evaluation and treatment of depression.

8 minutes

OH #5B-7

Relapse Prevention Techniques

- The techniques we will look at next are relapse prevention techniques.

Trainer Note:

- If the trainer is not familiar with participants:
- ***ASK***—How do you use relapse prevention techniques in your practice?
- Adjust detail of presentation to response (or to participant's knowledge of the topic based on trainer's familiarity with participants).
- Have those with more expertise provide concrete illustrations for novices.

- The TIP text begins this section with some descriptions of the term "relapse". These include:
  - The more general, "a breakdown or setback in a person's attempt to change or modify any target behavior" (Marlatt 1985, p. 3).
  - NIDA's elaboration of it as "any occasion of drug use by recovering addicts that violates their own prior commitment and that often they regret almost immediately" (NIDA 1993, p. 139).
  - And one that includes the notion of relapse as a process whereby "relapse can be understood not only as the event of resuming substance use, but also as a process in which indicators of increasing relapse risk can be observed prior to an episode of substance use, or lapse" (Daley 1987; Daley and Marlatt 1992).

OH #5B-8

- This view of relapse as a process is at the heart of relapse prevention models. On page 128, in the middle of the left column, the TIP summarizes the elements common to relapse prevention models.
  - A central element of all clinical approaches to relapse prevention is *anticipating problems* that are likely to arise in maintaining change and *labeling them as high-risk* situations for resumed substance use, then *helping clients to develop effective strategies* to cope with those high-risk situations without having a lapse.

Introduction to Case Study

- So what would relapse prevention techniques look like in practice? We are going to examine a case study where these techniques have been used with a client with COD. Please turn to page 134. *(Allow participants to access page 134.)*

Trainer Note:

- Ask participants to take turns reading the case aloud, or the trainer can read aloud (from the TIP or from the script below).

Case Study: Preventing Relapse in a Client with COD, p. 134

Stan Z. is a 32-year-old with diagnoses of recurrent major depression, antisocial personality disorder, crack/cocaine dependence, and polysubstance abuse. He has a 15-year history of addiction, including a 2-year history of crack addiction. Stan Z. has been in a variety of psychiatric and substance abuse treatment programs during the past 10 years. His longest clean time has been 14 months. He has been attending a dual-diagnosis outpatient clinic for the past 9 months and going to Narcotics Anonymous (NA) meetings off and on for several years. Stan Z. has been clean from all substances for 7 months. Following is a list of high-risk relapse factors and coping strategies identified by Stan Z. and his counselor:

High-Risk Factor 1

Stan Z. is tired and bored "with just working, staying at home and watching TV, or going to Narcotics Anonymous meetings." Recently, he has been thinking about how much he "misses the action of the good old days" of hanging with old friends and does not think he has enough things to do that are interesting.

Possible coping strategies for Stan Z. include the following:

1. Remind him of problems caused by hanging out with people who use drugs and using drugs by writing out a specific list of problems associated with addiction.
2. Challenge the notion of the "good old days" by looking closely at the "bad" aspects of those days.
3. Remind him of how far he has come in his recent recovery, especially being able to get and keep a job, maintain a relationship with one woman, and stay out of trouble with the law.
4. Discuss current feelings and struggles with an NA sponsor and NA friends to find out how they handled similar feelings and thoughts.

5. Make a list of activities that will not threaten recovery and can provide a sense of fun and excitement, and plan to start active involvement in one of these activities.

High-Risk Factor 2

Stan Z. is getting bored with his relationship with his girlfriend. He feels she is too much of a "home body" and wants more excitement in his relationship with her. He also is having increased thoughts of having sex with other women.

Possible coping strategies for Stan Z. include the following:

1. Explore in therapy sessions why he is really feeling bored with his girlfriend, noting he has a long-standing pattern of dumping girlfriends after just a few months.
2. Challenge his belief that the problem is mainly his girlfriend so that he sees how his attitudes and beliefs play a role in this problem.
3. Talk directly with his girlfriend in a nonblaming fashion about his desire to work together to find ways to instill more excitement in the relationship.
4. Remind him of potential dangers of casual sex with a woman he does not know very well, and remind him that he cannot reach his goal of maintaining a meaningful, mutual relationship if he gets involved sexually with another woman. His past history is concrete proof that such involvement always leads to sabotaging his primary relationship.

High-Risk Factor 3

Stan Z. wants to stop taking antidepressant medications. His mood has been good for several months and he does not see the need to continue medications.

Possible coping strategies include the following:

1. Discuss his concern about medications with his counselor and psychiatrist before making a final decision.
2. Review with his treatment team the reasons for being on antidepressant medications.
3. Remind him that because he had several episodes of depression, even during times when he has been drug-free for a long period, medication can help "prevent" the likelihood of a future episode of depression.

Source: Daley and Lis 1995, pp. 255-256.

Substance Abuse Management Module (SAMM)

- Before we move on to the next section, I would like to point out the Substance Abuse Management Module (SAMM; Roberts et al. 1999). Please turn to the chart on page 131. *(Allow participants to access page 131.)*
- ***ASK***—Has anyone had training on or formally implemented SAMM in their practice?

Trainer Note:

- Adjust your presentation of the following based on the response.

- As explained on page 130, SAMM is a detailed treatment manual that illustrates many relapse prevention therapy techniques. It was originally designed as part of a comprehensive approach to the treatment of co-occurring substance dependence and schizophrenia.
- SAMM offers a detailed cognitive-behavioral strategy for each of several common problems that clients face. Both counselor and client manuals are available.
- The excerpt from the book in the text box on page 131 shows how a clinician might work with a substance abuse treatment client with COD to help the client avoid drugs.

Trainer Note:

- Allow participants about a minute to look over the text box.

2 minutes

OH #5B-9

Repetition and Skills-Building to Address Deficits in Functioning

- We have talked about a wide variety of techniques so far that are available for use with clients with COD. However, the section starting on page 133 on repetition and skills-building reminds us that when applying these approaches we must keep in mind that clients with COD often have cognitive limitations, including difficulty concentrating. *(Allow participants to access page 133.)*
- On page 133, the second paragraph on the right provides strategies counselors can use to address cognitive limitations. These include:
  - Being more concrete and less abstract in communicating ideas
  - Using simpler concepts
  - Having briefer discussions
  - Repeating core concepts many times
  - Presenting information in multiple formats (verbally, visually, or affectively through stories, music, and experiential activities)
  - Role-playing real-life situations
    - For example, a client might be assigned to practice "asking for help" phone calls using a prepared script. This can be done individually with the counselor coaching, or in a group, to obtain feedback from the members.
- Another consequence of these deficits is that more substance abuse treatment may be required in order to attain and maintain abstinence when compared to clients without additional disorders or disabilities.
  - A primary reason for this is that abstinence requires the development and utilization of a set of recovery skills, and persons with mental disorders often have a harder time learning new skills.
  - Clients may require more support in smaller steps with more practice, rehearsal, and repetition.
  - The challenge is not to provide more intensive or more complicated treatment for clients with COD, but rather to tailor the process of acquiring new skills to the needs and abilities of the client.

5 minutes

OH #5B-10

Facilitate Client Participation in Mutual Self-Help Groups

- The final set of strategies addressed in Chapter 5 deals with helping clients participate in mutual self-help groups.

Trainer Note:

- If the trainer is not familiar with participants:
- ***ASK***—Is this part of your practice?

- As listed on page 135, the clinician can assist the client in several ways; by:
  - Helping the client locate an appropriate group. This may require:
    - Awareness on the part of the clinician of local 12-Step and other dual recovery mutual self-help groups.
    - Awareness of which 12-Step groups are known to be friendly to clients with COD, which have other members with COD, or are designed specifically for people with COD.
    - Visiting groups to see how they are conducted, collaborating with colleagues to discuss groups in the area, updating their own lists of groups periodically, and gathering information from clients.
  - Helping the client find a sponsor, ideally one who also has COD and is at a later stage of recovery.
    - Knowing that he or she has a sponsor who truly understands will be encouraging for the client. Also, some clients may "put people off" in a group and have particular difficulty finding a sponsor without the clinician's support.

  - Helping the client prepare to participate appropriately in the group.
    - Clients should be told the structure of a meeting, expectations of sharing, and how to participate in the closing exercises.
    - They may need to rehearse the kinds of things that are and are not appropriate to share at such meetings, and how to "pass".
    - The counselor should be familiar enough with group function and dynamics to actually "walk the client" through the meeting before attending.
  - Helping overcome barriers to group participation.
    - The clinician should be aware of the genuine difficulties a client may have in connecting with a group. For example, a client with cognitive difficulties may need help working out how he or she can physically get to the meeting and may need very detailed instructions.
- Debriefing with the client after he or she has attended a meeting to help process his or her reactions and prepare for future attendance.
    - The clinician's work does not end with referral to a mutual self-help group. The clinician must be prepared to help the client overcome any obstacles after attending the first group to ensure engagement in the group. The case study for this section is a good illustration.

Introduction to Case Study

- Please turn to page 136. *(Allow participants to access page 136.)*

Trainer Note:

- Ask participants to take turns reading the case aloud, or the trainer can read aloud (from the text or from the script below).

Case Study: Helping a Client Find a Sponsor, p. 136

Linda C. had attended her 12-Step group for about 3 months, and although she knew she should ask someone to sponsor her, she was shy and afraid of rejection. She had identified a few women who might be good sponsors, but each week in therapy, she stated that she was afraid to reach out, and no one had approached her, although the group members seemed "friendly enough." The therapist suggested that Linda C. "share" at a meeting, simply stating that she would like a sponsor but was feeling shy and didn't want to be rejected. The therapist and Linda C. role-played together in a session, and the therapist reminded Linda C. that it was okay to feel afraid and if she couldn't share at the next meeting, they would talk about what stopped her.

After the next meeting, Linda C. related that she almost "shared" but got scared at the last minute, and was feeling bad that she had missed an opportunity. They talked about getting it over with, and Linda C. resolved to reach out, starting her sharing statement with, "It's hard for me to talk in public, but I want to work this program, so I'm going to tell you all that I know it's time to get a sponsor." This therapy work helped Linda C. to put her need out to the group, and the response from group members was helpful to Linda C., with several women offering to meet with her to talk about sponsorship. This experience also helped Linda C. to become more attached to the group and to learn a new skill for seeking help. While Linda C. was helped by counseling strategies alone, others with "social phobia" also may need antidepressant medications in addition to counseling.

2 minutes

Wrap up

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.
- Encourage participants to read the chapter.

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 5B

Introduction

Strategies for Working with Clients with Co-Occurring Disorders:
Techniques for a Working with Clients with COD

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

In This Module . . .

- Module 5A
  - Guidelines for a successful Therapeutic Relationship with a Client who has COD

- **Module 5B**
  - Techniques for Working with Clients with COD

Key Techniques for Working With Clients Who Have COD

1. **Motivational enhancement consistent with the client's stage of change.**
2. Contingency management techniques to address specific target behaviors.
3. Cognitive-behavioral therapeutic techniques.
4. Relapse prevention techniques.
5. Repetition and skills-building to address deficits in functioning.
6. Facilitate client participation in mutual self-help groups.

Motivational Interviewing (MI)

Motivational Interviewing (MI) is a *"client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence."*

Source: Miller and Rollnick 2002, p. 25.

Key Techniques for Working With Clients Who Have COD

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6. Facilitate client participation in mutual self-help groups.

Relapse Prevention

". . . a central element of all clinical approaches to relapse prevention is anticipating problems that are likely to arise in maintaining change and labeling them as high-risk situations for resumed substance use, then helping clients to develop effective strategies to cope with those high-risk situations without having a lapse."

TIP 42, p. 128

Key Techniques for Working With Clients Who Have COD

1. Motivational enhancement consistent with the client's stage of change.
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5. Repetition and skills-building to address deficits in functioning.
6. **Facilitate client participation in mutual self-help groups.**

MODULE 6A: Traditional Settings and Models: Essential Programming for Clients with COD

Objectives

- Chapter 6 of the TIP examines two (2) questions: 1) What happens to clients with co-occurring disorders (COD) who enter traditional substance abuse settings? and 2) How can programs provide the best possible services to these people? The chapter's material has been divided into three (3) modules:
  - ***Module 6A*** examines essential programming recommendations and general considerations for treatment of clients with COD.
  - *Module 6B** explores outpatient substance abuse treatment programs for clients with COD paying particular attention to issues related to designing, implementing, evaluating and sustaining such programs.
  - *Module 6C** explores residential substance abuse treatment programs for clients with COD paying particular attention to issues related to designing, implementing, evaluating and sustaining such programs.

* The trainer may opt to present either 6B or 6C depending on which is most appropriate to the participants' needs.

Trainer Note:

The following trainer notes are for Module 6A only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Copies of the TIP ZIP test, one per participant *(See Handbook section for master copy.)*
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 6A.1-6A.8
- Newsprint sheets and markers for small group work
- Masking tape to post newsprint on wall
- Kitchen timer
- Markers and Post-It Notes for participants to use on their TIP texts

Module Design

- Module 6A is a blend of small group (or dyadic) discussion, brief lecture, and constant interaction between participants and the TIP text. Informal interaction between trainer and participants has also been built into the script to help participants connect the information to their day-to-day practice. This type of interaction, and the overall flow of the module, have been designed with counselors in mind and may need to be adjusted if most of the participants are administrators. *(See Option for Administrators below).*
- Informal interaction may also have to be modified depending on the size of the group and the interests and needs of participants who may be more responsive to some topics, or who may need more time for one topic and less time for another.

Time management

- Because informal interaction between trainer and participants has been built into much of the script, the trainer will need to keep tight control of the time so that the module's content can be covered in the allotted 45 minutes. The trainer should be familiar with the script and determine ahead of time the informal interactions that are most appropriate and those that can be skipped should time become an issue.
- Formal discussion activities should be implemented as scripted. Careful attention to time is important during both the group work and report out phases. Minimal time has been allotted to both group discussion and report out due to time constraints and as a way to keep participants focused on the task. Reports must also be brief and to the point. Facilitators should monitor groups to make sure they stay on task and comply with timelines. A kitchen timer with a loud bell can be a valuable resource.

Seating

- Formal small group discussion is designed for small groups of 3-5 participants. If the total number of participants is small then dyads can be used instead of small groups. Should the trainer prefer participants work with someone other than the persons they are likely to sit with initially, this re-seating should be carried out quickly before the module begins, perhaps as part of a quick ice-breaker or warm-up activity.

Option for Administrators

- If the majority of the participants are administrators, the trainer may wish to reorder the module and present the *Essential Programming for Clients with COD* discussion activities and lecture first, before presenting the section on *General Considerations for Treatment*.
- An alternative version for administrators of the discussion that concludes the essential programming section is included in the slides. This option begins with the same task as that in the counselor version: by asking participants to "Renumber your group's list of seven (7) recommendations in order of importance (if you wish to change the order)." Then administrators are asked to decide, "Does your program reflect these seven (7) recommendations? In this order?"

Suggested Timetable for Module 6A

Introduction ■ Reconvening and Review of Module 5B ■ In This Module	3 minutes
TIP ZIP Test *Optional*	5 minutes
General Considerations for Treatment ■ Modifications to Group Work – Discussion—*2 minutes* – Report Out—*3 minutes* ■ Working in Groups ■ Involving Clients in Treatment and Program Design ■ Family Education	14 minutes
Essential Programming for Clients with COD ■ Quick TIP Exercise—7 Recommendations ■ Report Out ■ Screening, Assessment, and Referral ■ Physical and Mental Health Consultation ■ Prescribing Onsite Psychiatrist ■ Medication and Medication Monitoring ■ Psychoeducational Classes ■ Double Trouble Groups ■ Dual Recovery Groups	15 minutes
Discussion—List Revision ■ Small Group Work—*2 minutes* ■ Report Out—*3 minutes*	5 minutes
Wrap up ■ Review of TIP ZIP Test	3 minutes
TOTAL	**45 minutes**

3 minutes

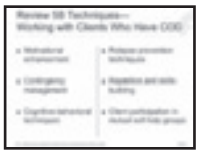
OH #6A-1

Introduction

Reconvening and Review of Module 5B

Trainer Note:

- This section briefly reviews the main topics in Module 5B and helps participants recognize how to apply the information in Module 5B to their everyday practice.
- If the facilitator is familiar with the participants and their daily practice, he or she may wish to identify applications of the information in Module 5B ahead of time. The facilitator can then tease these examples out or provide them if participants do not think of them. If the facilitator is not familiar with the participants, he or she can probe for responses if participants are not forthcoming. For example, it is highly likely that participants have recently used some contingency management techniques and repetition and skills building.
- The facilitator should be very careful regarding the time allotted for this initial review and control discussion accordingly. For questions about the material in Module 5B refer participants to the text or to other resources.
- Check that everyone has a copy of the TIP. Lend copies or have people share.
- Review Module 5B session. (If Module 5B has not been presented previously, begin with the “In This Module” section below and use the TIP ZIP Test option).



OH #6A-2

- In our last session, we examined a variety of techniques that have been found to be particularly helpful in the treatment of clients with substance abuse, techniques that are being adapted for work with clients with COD. We also reviewed cases that illustrated the techniques discussed:
  - Motivational enhancement
  - Contingency management
  - Cognitive-behavioral techniques
  - Relapse prevention techniques
  - Repetition and skills-building
  - Client participation in mutual self-help groups
- ***ASK***—Did you use any of these since our last meeting? *(Solicit a couple of participant responses. If no response...)*
- ***ASK***—Did anyone use positive reinforcers such as praise or prizes or privileges? If so, you used contingency management techniques. How about repetition and skills-building? *(Briefly probe to tease out examples of how participants applied techniques in their practice.)*

In This Module . . .

OH #6A-3

- Chapter 6 in your text takes a programmatic perspective. It is a valuable resource for substance abuse treatment agencies that treat clients with COD. The chapter examines two (2) questions: 1) What happens to clients with COD who enter traditional substance abuse settings? and 2) How can programs provide the best possible services to these people?
- Module 6A examines the essential programming elements in COD programming for substance abuse treatment agencies that treat clients with COD. These are the consensus panels' recommendations for providing essential services for people with COD. These elements are applicable in both residential and outpatient programs. The module also addresses some general considerations for treatment.
- Modules 6B and 6C provide an overview of outpatient and residential settings. We will focus on issues related to designing, implementing, evaluating and sustaining both outpatient and residential substance abuse treatment programs for clients with COD.
- These areas are covered more extensively in Chapter 6 than is possible to cover in our sessions. The text also highlights promising treatment models that have emerged both within the substance abuse field and elsewhere that will be of interest to all participants.

5 minutes

TIP ZIP Test *Optional*

Trainer Note:

- The TIP ZIP test will focus participant attention on the topic and can be used if Module 5B was not previously presented. Each participant will need a copy of the test. A master copy is included in the handout section.
- Five (5) minutes is allowed for the test. Use a kitchen timer and enforce the time.
- Participants may NOT use their TIP during test taking. Participants may discuss their responses with their neighbor during the last two (2) minutes of test taking and change their responses if they wish.
- Once completed, tell participants that they will auto-correct their tests. Answers will become evident as the session progresses. Small prizes such as candy or markers can be given out at the end of the session to those with the most correct answers.

- Before we start examining the chapter, however, we have a short TIP ZIP Test to focus our attention on some of the information we will cover today. You will have five (5) minutes to complete the test. Remember: there are no grades. This is just a way of focusing on our topic. Please close your TIP texts and do not peek. During the last two (2) minutes, you can check with your neighbor and change your responses if you wish. But you can't read the TIP yet.

Trainer Note:

- Set timer for five (5) minutes.
- Give participants two (2) minute warning so they can check responses with their neighbor.
- Call time at the end of five (5) minutes.
- After TIP ZIP Test, continue lecture.

- As we go through the module, we will have opportunities to check your responses and decide what the correct answer is. At the end of the session, we will take a final tally of our responses.

14 minutes

General Considerations for Treatment

Trainer Note:

- In the TIP text, this section follows the section on *Essential Programming for Clients with COD* but it is presented first here to more quickly engage participant interest and connect module content to practice.

- When treating persons with COD, there are three (3) general considerations that the TIP text urges providers to keep in mind.
- The first of these addresses the need for modifications to group therapy for clients with COD.

Modifications to Group Work

Discussion

2 minutes

OH #6A-4

Trainer Note:

- This discussion sets the tone for the module which is intended to highlight the TIP as an expert resource while acknowledging and encouraging exchange of participant expertise regarding the treatment of clients with COD. This type of interaction continues informally during the subsequent lecture and guided-reading on *General Considerations for Treatment* and throughout the rest of the module.
- With a partner or in small groups participants are asked to quickly identify: *What three (3) modifications would you advise a novice counselor to make when conducting group therapy with clients with COD?* This novice counselor would be experienced in group therapy but not with clients who have COD.
- Participants must focus on the task as only two (2) minutes are allotted for group work.
- During the report out, each group or dyad shares one (1) modification (that has not been previously mentioned). When all have responded, the facilitator can ask if anyone has additional recommendations and go around groups again, or move on to the script. No more than three (3) minutes should be spent on the report out.

- The script then provides modifications suggested by the TIP. Participant responses should be integrated into this presentation.

- Before we look at some of the suggestions in the TIP text, I would like to take advantage of the experience available in this room. With a partner (or your group), I would like you to imagine you are advising a counselor who is familiar with group therapy but is a novice when it comes to working with clients with COD. What three (3) modifications or changes would you suggest to that counselor when working in groups with clients who have COD?

Trainer Note:

- Set timer for two (2) minutes. Call time.

3 minutes

Report Out

- Now, I would like each group to share one (1) recommendation from your list. You can pass if your recommendation is the same as one already given.

Trainer Note:

- Have each dyad or group share one (1) recommended modification.
- When all have responded, ask if anyone had any other recommendations and go around groups again.
- Spend no more than three (3) minutes reporting out.

OH #6A-5

Working in Groups

Trainer Note:

- For the following list of recommendations, mention but do not elaborate on suggestions already presented by the groups in the previous discussion.
- If time is short, present only part of the list and urge participants to explore the other valuable suggestions by reading the chapter.

- On page 142, the text provides some recommendations regarding modifications to group therapy for clients with COD. *(Allow participants to access page 142.)*
- Some of these recommendations include:
  - Reducing the emotional intensity of interpersonal interaction in COD group sessions. Issues that are nonprovocative to clients without COD may lead to reactions in clients with COD.
  - Because many clients with COD often have difficulty staying focused, their treatment groups usually need stronger direction from staff than those for clients who do not have COD.
  - Co-leaders are especially important in these groups, as one leader may need to leave the group with one member, while the group continues with the co-leader. Peers who have completed the program or advanced to its latter stages can sometimes be used as group co-facilitators.
  - Some persons with COD have trouble sitting still, while others may have trouble getting moving at all (for instance, some people with depression). Therefore, the duration should be shortened to less than an hour, with the typical group or activity running for no more than 40 minutes.
  - Because of the need for stability, the groups should run regularly and without cancellation.
  - Because many clients with COD have difficulty in social settings, group sizes may need to be smaller than is typical. It is not uncommon for groups tailored to individuals with COD to consist of between two (2) and (4) four individuals in the early stages.

- Considerable tolerance is needed for varied (and variable) levels of participation depending on the client's level of functioning, stability of symptoms, response to medication, and mental status. Many clients with serious mental illness (e.g., those with a diagnosis of schizophrenia, schizoid and paranoid personality) may not fit well in groups and must be incorporated gradually at their own pace and to the degree they are able to participate.
  - Even minimal or inappropriate participation can be viewed as positive in a given case or circumstance.
- Verbal communication from group leaders should be brief, simple, concrete, and repetitive. This is especially important to reach clients with cognitive and functional impairments.
- Affirmation of accomplishments should be emphasized over disapproval or sanctions. Negative behavior should be amended rapidly with a positive learning experience designed to teach the client a correct response to a situation.
- In general, group leaders will need to be sensitive and responsive to needs of the client with COD and the addition of special training can enhance his or her competency. TIP 41, *Substance Abuse Treatment: Group Therapy* (Center for Substance Abuse Treatment [CSAT] 2005) contains more information on the techniques and types of groups used in substance abuse treatment.

Involving Clients in Treatment and Program Design

- The second general consideration for treatment of persons with COD addresses the importance of finding meaningful ways of including clients in treatment and program design.
- Because clients can provide important guidance relative to their treatment and valuable feedback on program design and effectiveness, they should be involved in program discussions.
- On page 143, your text provides a list of suggested guidelines for involving clients. *(Allow participants to access page 143.)*
- ***ASK***—Glance over this list. With a show of hands, has anyone had experience, especially successful experience, using any of these? *(Ask a few of those who have raised their hands to briefly explain their experiences.)*
- ***ASK***—Does anyone have other suggestions that have worked well? *(Allow a few participants to share their experiences.)*

Family Education

- The final consideration suggested by your text speaks to the importance of informed family members in the recovery process. Since families can have a powerful influence on a client's recovery, it is especially important to reach out to the families of persons with COD and help them understand more about COD and how they can best support the client and help the person recover.
- The text emphasizes that instruction provided by programs should NOT be in a lecture format. Instead, the information should be presented in an *interactive* style that allows for questions.
- On page 143 is a list of the essential information to include. *(Allow participants to access page143.)*
  - The name of the disorder
  - Its symptoms
  - Its prevalence
  - Its cause
  - How it interacts with substance abuse-that is, the implications of having both disorders
  - Treatment options and considerations in choosing the best treatment
  - The likely course of the illness
  - What to expect
  - Programs, resources, and individuals who can be helpful
- ***ASK***—What are some successes you have had involving and educating families of clients with COD? *(Solicit responses from a few participants.)*

15 minutes

Essential Programming for Clients with COD

Trainer Note:

- Informal interaction between trainer and participants has been built into this brief review of the seven (7) elements the text considers essential to substance abuse treatment agency programs for clients with COD.
- Trainers will need to be familiar with the text and prepared for the scripted interactions.

- We now shift to a more programmatic perspective, to the essential elements programs require to meet the needs of individuals with COD.
- On the bottom of page 141, in the *Advice to Administrators* purple box, are seven (7) recommended program elements for providing essential services for people with COD. *(Have participants turn to page 141.)*
- These are program components that should be developed by any substance abuse treatment program seeking to provide integrated substance abuse and mental health services to clients with COD (that is, to attain the level of capacity associated with the "COD capable" classification we defined earlier in Chapter 2). These components include:
  - Screening, assessment, and referral for persons with COD
  - Physical and mental health consultation
  - Prescribing onsite psychiatrist
  - Medication and medication monitoring
  - Psychoeducational classes
  - Double trouble groups (onsite)
  - Dual recovery self-help groups (offsite)

OH #6A-6

Quick TIP Exercise—7 Recommendations

Trainer Note:

- This activity focuses participant attention on the seven (7) *Recommendations for Providing Essential Services for People with COD* and reveals participant attitudes and experiences regarding these recommendations.
- For facilitators unfamiliar with the participants' everyday practice, it will also provide insight about how participants use the recommendations in their workplace.
- In small groups participants are asked to reorder the list provided in the text based on the group's perception of each element's level of importance. Two (2) minutes are allotted for this.
- During the report out, which should last no longer than three (3) minutes, the group briefly explains their choices for first and second place. The facilitator should call attention to any overall similarities and differences among resulting lists, and integrate participant comments as much as possible into the subsequent presentation.
- Hand out newsprint and markers if these were not already placed on group tables.
- Instruct participants to renumber the recommendations based on the group's opinion of their importance.

- In your text, the seven (7) recommendations are listed in numerical order. With your group, I would like you to renumber them, ranking them this time based on your assessment of their importance to the success of programs serving people with COD. The recommendation your group feels is the most important would go first. And so on.

- Write the list on your newsprint. Be prepared to give your reasons why. You have two (2) minutes.

- If some of these are not entirely familiar to you, don't worry. Create the list based on what you think they mean. You will have the opportunity to revisit the list and change it later.

Trainer Note:

- Set timer for two (2) minutes. Call time.
- Have groups tape their lists on wall or hold up as they report out.

Report Out

- You will each have 20 seconds to briefly tell us why you put your first and second choices in those spots. We will discuss these lists later in the module, but your perspectives at this point are important.

Trainer Note:

- Allow spokesperson for each group 20 seconds to share reasons for first and second place ranking. Keep it brief!
- Note aloud any overall similarities or differences among rank-order lists.
- Integrate relevant participant comments as much as possible into the presentation below.

- Now that we have an idea of the groups' perspectives regarding some of these program components, we will explore them a little further. As usual, I want to assure you that much more information is provided in your text than we can cover in our session, so I encourage you to read it.
- Please turn to page 138. *(Allow participants to access page 138.)*

Screening, Assessment, and Referral

- As discussed in previous modules, and most thoroughly in Chapter 4 of your TIP text, it is the responsibility of each provider to be able to identify clients with both mental and substance use disorders and ensure that they have access to the care needed for each disorder.
- This requires that the substance abuse treatment program has in place appropriate *procedures for screening, assessing, and referring* clients with COD.
- If the disorder is beyond the agency's capacity, then referral is made to a suitable residential or mental health facility, or other community resource.
- To ensure that the referral is suitable to the treatment needs of persons with COD, mechanisms for ongoing consultation and collaboration must be developed and implemented.
- ***ASK***—In your everyday practice, what has been a particularly successful mechanism for ongoing consultation and collaboration?

Trainer Note:

- Solicit responses from participants.
- Promote an exchange of "best practices" during the discussion.
- If participants are not forthcoming, briefly probe for barriers to such mechanisms and for any success stories at overcoming them.

Physical and Mental Health Consultation

Trainer Note:

- If the trainer is not familiar with participants or agency:
- ***ASK***—What kinds of mental health specialists are available to you in your practice?
- Allow a few participants to respond.
- Check to see if the experience of the rest of the participants is similar or different.
- Tailor presentation of this and next section based on responses.

- Standard staffing in any substance abuse treatment program that serves a significant number of clients with COD should include mental health specialists and consultation for assessment, diagnosis, and medication.
  - Adding a master's level clinical specialist with strong diagnostic skills and expertise in working with clients with COD can strengthen an agency's ability to provide services for these clients.
- A psychiatrist provides services crucial to sustaining recovery and stable functioning for people with COD: assessment, diagnosis, periodic reassessment, medication, and rapid response to crises.
  - If lack of funding prevents the substance abuse treatment agency from hiring a consultant psychiatrist, the agency could establish a collaborative relationship with a mental health agency to provide those services. Your text provides more information on such arrangements.

Prescribing Onsite Psychiatrist

- Adding an onsite psychiatrist in an addiction treatment setting to evaluate and prescribe medication for clients with COD has been shown to improve treatment retention and decrease substance use (Charney et al. 2001; Saxon and Calsyn 1995).
- An onsite psychiatrist is often the most effective way to overcome barriers presented by offsite referral, including distance and travel limitations, cost, and the difficulty of becoming comfortable with different staff.
- The text notes that some substance abuse programs may be reluctant to hire a psychiatrist or to provide psychiatric services. The consensus panel suggests that this reluctance may be overcome by carrying out agency wide discussions regarding the types of clients with COD seen by the agencies, how their services are coordinated, and the barriers clients experience to receiving all the elements of COD treatment. Diagnosis and treatment of mental disorders is often the largest and most obviously missing element of good, integrated onsite COD treatment.
  - An additional advantage of an onsite psychiatrist is the development of substance abuse treatment staff and enhancement of their comfort and skill in assisting clients with COD through the psychiatrist's participation in clinical team meetings and staff seminars.

Medication and Medication Monitoring

Trainer Note:

- If the trainer is not familiar with the participants or the agency:
- ***ASK***—How is medication and medication monitoring handled in your agency?
- Tailor presentation based on responses.

- Many clients with COD require medication to control their psychiatric symptoms and to stabilize their psychiatric status. The importance of stabilizing the client with COD on psychiatric medication when indicated is now well established in the substance abuse treatment field.
- One important role of the psychiatrist working in a substance abuse treatment setting is to provide psychiatric medication based on the assessment and diagnosis of the client, with subsequent regular contact and review of medication. These activities include careful monitoring and review of medication adherence.
- As we have mentioned several times, the counselor also plays an important role in monitoring. Appendix F is a valuable resource to counselors regarding medications and effective interaction on this topic with physicians and clients. *(Allow participants to access and examine Appendix F if it has not been accessed in previous modules.)*

Psychoeducational Classes

- Substance abuse treatment programs can help their clients with COD by offering psychoeducational classes. Especially important are classes that address 1) mental and substance use disorders, and 2) relapse prevention.
- ***ASK***—In your experience with clients with COD, what has been the value of classes that talk about mental and substance use disorders? *(Allow a few participants to respond.)*
- ***ASK***—How about classes on relapse prevention for both disorders? How have these been useful? *(Allow a few participants to respond.)*
- ***ASK***—What are lessons you have learned that helped improve the psychoeducational classes? *(Allow a few participants to respond.)*

Trainer Note:

- Add any points not already made by participants from script material below.

Mental and substance use disorders classes

- Classes about disorders typically focus on the signs and symptoms of mental disorders, medication, and the effects of mental disorders on substance abuse problems.
- Such classes increase client awareness of their specific problems in a safe and positive context. Therefore, it is important, that education about mental disorders be open and generally available within substance abuse treatment programs. Information should be presented in a factual manner, similar to the presentation of information on sexually transmitted diseases (STDs).
  - The text suggests use of synopses of mental illnesses that have been prepared by mental health clinics for clients in terms that are factual but unlikely to cause distress.
  - Also useful are materials available through government agencies and advocacy groups, such as those listed in Appendix I of your text. These are written for the layperson and are helpful for the substance abuse treatment counselor as well as for the client.

Relapse prevention classes

- Psychoeducational classes can also focus on helping clients become aware of cues or "triggers" that make them more likely to abuse substances and help them develop alternative coping responses to those cues.
- Similarly, basic treatment agencies can offer clients training on recognizing cues for the return of psychiatric symptoms and for affect or emotion management, including how to identify, contain, and express feelings appropriately.

Double Trouble Groups (Onsite)

- Another recommendation of the consensus panel is the inclusion of onsite groups such as "Double Trouble" groups. These provide a forum for discussion of the interrelated problems of mental disorders and substance abuse, helping participants to identify triggers for relapse.
- Through participation, the individual with COD develops perspective on the interrelated nature of mental disorders and substance abuse and becomes better able to view his or her behavior within this framework.
- Double Trouble groups also can be used to monitor medication adherence, psychiatric symptoms, substance use, and adherence to scheduled activities. Double Trouble provides a constant framework for assessment, analysis, and planning.

Dual Recovery Groups (Offsite)

- Dual recovery mutual self-help groups exist in many communities. Where available, substance abuse treatment programs can refer clients to dual recovery mutual self-help groups, which are tailored to the special needs of a variety of people with COD.
  - A list of such programs and contact information is available in Appendix J.

5 minutes

Discussion—List Revision

Trainer Note:

- This discussion closes the section on essential programming and allows participants to synthesize the material presented.
- In small groups participants are asked to review the rank-order list they created earlier and change the order if they wish. Then they are asked if there are any essential elements they think should be added.
- Two (2) minutes are allotted for this discussion. The report out should last no longer than three (3) minutes.

OH #6A-7

- Now that we have briefly discussed the seven (7) recommendations, take a minute to look at the list you made ranking them in order of importance. If your group has changed its mind about the order, make any changes you think appropriate.
- Then, consider if there are any essential elements that you feel have been left out. Remember, these are recommended essential elements for programs in substance abuse treatment agencies that treat clients with COD.
- You will have two (2) minutes.

Trainer Note:

- Set timer for two (2) minutes. Call time.

Report Out

Trainer Note:

- Solicit responses from one (1) or two (2) groups. Then invite other groups to share any responses that are different.
- Spend no more than three (3) minutes reporting out.

3 minutes

Wrap up

Trainer Note:

- The trainer closes the module with a brief summary statement.

- We have talked about the seven (7) *Recommendations for Providing Essential Services for People with COD* (point out lists on wall) as well as some important considerations when working with clients with COD, such as modifications to group work, involving the client in treatment, and educating the family.

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Review the TIP ZIP Test results if the test was used.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

Module 6A
TIP ZIP TEST

1. T or F—It is the responsibility of each provider to be able to identify clients with both mental and substance use disorders and ensure that they have access to the care needed for each disorder. *(p. 138)*

2. Adding an onsite psychiatrist in an addiction treatment setting to evaluate and prescribe medication for clients with COD has been shown to:
    a. Improve treatment retention
    b. Decrease substance abuse
    c. Both a and b
    d. None of the above *(p. 139)*

3. Substance abuse treatment programs can help their clients with COD by offering psychoeducational classes on:
    a. Signs and symptoms of mental disorders
    b. Medication
    c. Effects of mental disorders on substance abuse problems
    d. Cues or "triggers" of substance abuse
    e. All of the above
    f. Classes are not a good strategy for most clients with COD *(p. 140)*

4. Double Trouble refers to:
    a. Interrelated problems of drug and alcohol abuse
    b. Interrelated problems of mental disorders and substance abuse
    c. Interrelated problems of mental disorders and homelessness *(p. 141)*

5. The following is NOT a recommended modification to group therapy for clients with COD:
    a. Longer sessions
    b. Regular scheduling
    c. Smaller groups
    d. Use of a co-leader
    e. Less emotional intensity *(p. 142)*

6. T or F—Programs should provide family members and significant others with lectures on mental disorders and substance abuse, how the disorders interact with one another, implications of having COD, and the treatment options available to the client. *(p. 143)*

Module 6A
TIP ZIP TEST—*KEY*

1. ***T*** or F—It is the responsibility of each provider to be able to identify clients with both mental and substance use disorders and ensure that they have access to the care needed for each disorder. *(p. 138)*

2. Adding an onsite psychiatrist in an addiction treatment setting to evaluate and prescribe medication for clients with COD has been shown to:
   a. Improve treatment retention
   b. Decrease substance abuse
   c. ***Both a and b***
   d. None of the above *(p. 139)*

3. Substance abuse treatment programs can help their clients with COD by offering psychoeducational classes on:
   a. Signs and symptoms of mental disorders
   b. Medication
   c. Effects of mental disorders on substance abuse problems
   d. Cues or "triggers" of substance abuse
   e. ***All of the above***
   f. Classes are not a good strategy for most clients with COD *(p. 140)*

4. Double Trouble refers to:
   a. Interrelated problems of drug and alcohol abuse
   b. ***Interrelated problems of mental disorders and substance abuse***
   c. Interrelated problems of mental disorders and homelessness *(p. 141)*

5. The following is NOT a recommended modification to group therapy for clients with COD:
   a. ***Longer sessions***
   b. Regular scheduling
   c. Smaller groups
   d. Use of a co-leader
   e. Less emotional intensity *(p. 142)*

6. T or ***F***—Programs should provide family members and significant others with lectures on mental disorders and substance abuse, how the disorders interact with one another, implications of having COD, and the treatment options available to the client. **This should NOT be in lecture form, but in "an interactive style that allows questions."** *(p. 143)*

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 6A

Introduction

Traditional Settings and Models:
Essential Programming for Clients with COD

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Review 5B Techniques—Working with Clients Who Have COD

- Motivational enhancement
- Contingency management
- Cognitive-behavioral techniques
- Relapse prevention techniques
- Repetition and skills-building
- Client participation in mutual self-help groups

In This Module . . .

- **Module 6A**
  - Essential Programming & General Considerations for Treatment of Clients with COD
- Module 6B
  - Outpatient Substance Abuse Treatment Programs for Clients with COD
- Module 6C
  - Residential Substance Abuse Treatment Programs for Clients with COD

Discussion—
Modifications to Group Work

With your partner or small group discuss:

- *What 3 modifications would you advise a novice counselor to make when conducting group therapy with clients with COD?*

(2 minutes)

Modifications to Group

- Reduced intensity
- Stronger direction
- Co-leaders
- Shorter duration
- Regular schedules
- Smaller groups
- Varied participation
- Brief, simple, concrete, repetitive
- Emphasis on affirmation

Quick TIP Exercise—7 Recommendations

With your group:

- Rank-order the seven (7) recommendations in order of importance.
- Be prepared to give your reasons.

(2 minutes)

1. Screening, assessment, & referral for persons with COD
2. Physical & mental health consultation
3. Prescribing onsite psychiatrist
4. Medication & medication monitoring
5. Psychoeducational classes
6. Double trouble groups (onsite)
7. Dual recovery self-help groups (offsite)

Discussion—List Revision

With your partner or group

1. Renumber your group's list of seven (7) recommendations in order of importance *(if you wish to change the order).*

2. Are there any essential program elements you would add?

(2 minutes)

Discussion—List Revision Option for Administrators

With your partner or group

1. Renumber your group's list of seven (7) recommendations in order of importance *(if you wish to change).*

2. Does your program reflect these seven (7) recommendations? In this order?

(2 minutes)

MODULE 6B: Traditional Settings and Models: Outpatient Substance Abuse Treatment Programs for Clients with COD

Objectives

- Chapter 6 of the TIP examines two (2) questions: 1) What happens to clients with COD who enter traditional substance abuse settings? and 2) How can programs provide the best possible services to these people?
- The chapter's material has been divided into three (3) modules:
  - *Module 6A* examines essential programming recommendations and general considerations for treatment of clients with COD.
  - ***Module 6B**** explores outpatient substance abuse treatment programs for clients with COD paying particular attention to issues related to designing, implementing, evaluating and sustaining such programs.
  - *Module 6C** explores residential substance abuse treatment programs for clients with COD paying particular attention to issues related to designing, implementing, evaluating and sustaining such programs.

* The trainer may opt to present either 6B or 6C depending on which is most appropriate to the participants' needs.

Trainer Note:

- The following trainer notes are for Module 6B only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 6B.1-6B.12
- Newsprint sheets and markers for small group work
- Copies—one (1) per small group-of the handout, *Specialized Treatment Model Grid (See Handout section for master copy.)*
- Masking tape to post newsprint on wall
- Kitchen timer
- Markers and Post-It Notes for participants to use on their TIP texts
- Small incentives (prizes) such as candy or trinkets for final activity

Module Design

- Module 6B is a blend of small group (or dyadic) discussion, brief lecture, and constant interaction between participants and the TIP text. Informal interaction between trainer and participants has also been built into the script to help participants connect the information to their day-to-day practice. This type of interaction, and the overall flow of the module, have been designed with counselors in mind and may need to be adjusted if most of the participants are administrators.
- Some of the information is familiar because it has been covered in earlier modules, such as those on screening and assessment, training, etc. The material is included in Module 6B in case the earlier modules have not yet been presented. Also, the material presented in this module is more specific to the setting being described. If the trainer feels a topic has been adequately covered in a previous module, then the trainer can refer to that module, briefly summarize the point, and continue with the script.

Time management

- Several formal and informal interactions are included in this module. The trainer will need to determine ahead of time which are most likely to meet the group's needs and which can be summarized or deleted if time becomes a concern.

Seating

- Formal small group discussion is designed for small groups of 3-5 participants. If the total number of participants is small then dyads can be used instead of small groups. Should the trainer prefer participants work with someone other than the persons they are likely to sit with initially, this re-seating should be carried out quickly before the module begins, perhaps as part of an icebreaker or warm-up activity.

Suggested Timetable for Module 6B

Introduction ■ Reconvening and Review of Module 6A ■ In This Module ■ Empirical Evidence of Effectiveness	3 minutes
Designing Outpatient Programs for Clients with COD ■ Screening and Assessment ■ Centralized Intake ■ Reassessment ■ Referral and Placement ■ Engagement	5 minutes
Quick TIP Exercise ■ Small Group Work—*3 minutes* ■ Report Out—*6 minutes*	9 minutes
Designing Outpatient Programs for Clients with COD *(continued)* ■ Discharge Planning ■ Continuing Care	4 minutes
Implementing Outpatient Programs for Clients with COD ■ Staffing and Training	2 minutes

Suggested Timetable for Module 6B — *continued*

Evaluating Outpatient Programs for Clients with COD ■ Define Operational Goals of the Program in Terms of Client Behaviors ■ Decide on Study Clients and Sampling ■ Locate and/or Develop Instruments ■ Develop a Plan for Data Collection ■ Develop a Plan for Analysis and Reporting	5 minutes
Sustaining Outpatient Programs for Clients with COD ■ Financing Integrated Treatment ■ Planning for Organizational Change	2 minutes
Examples of Outpatient Programs ■ Assertive Community Treatment (ACT) – Empirical Evidence for ACT—*Optional* ■ Intensive Case Management (ICM) – Empirical Evidence—*Optional*	4 minutes
TIP Exercise—ACT / ICM Grid ■ Small Group Work—*5 minutes* ■ Report Out—*5 minutes*	10 minutes
Wrap up	1 minute
TOTAL	**45 minutes**

3 minutes

OH #6B-1

Introduction

Reconvening and Review of Module 6A

Trainer Note:

- This section briefly reviews the main topics of Module 6A.
- Check that everyone has a copy of the TIP. Lend copies or have people share.
- Review Module 6A session. (If Module 6A has not been presented previously, proceed to "In This Module.")

OH #6B-2

OH #6B-3

- As we discussed last time, Chapter 6 takes a programmatic perspective. The chapter examines two (2) questions: 1) What happens to clients with COD who enter traditional substance abuse settings? and 2) How can programs provide the best possible services to these people?
- Module 6A examined the essential programming elements in COD programming for substance abuse treatment agencies that treat clients with COD. These elements are applicable in both residential and outpatient programs:
  - Screening, assessment, and referral
  - Physical and mental health consultation
  - Prescribing onsite psychiatrist
  - Medication and medication monitoring
  - Psychoeducational classes
  - Double trouble groups (onsite)
  - Dual recovery self-help groups (offsite)
- The module also addressed some general considerations for treatment such as:
  - Modifications when working in groups that include clients with COD.
  - Involving clients in treatment and program design.
  - The importance of educating clients' family members and significant others regarding mental disorders, substance abuse, as well as on how the disorders interact with each other.

In This Module . . .

OH #6B-4

- In Module 6B we will take a closer look at outpatient settings with particular attention to issues related to:
  - Designing
  - Implementing
  - Evaluating
  - Sustaining outpatient substance abuse treatment programs for clients with COD
- These areas are covered more extensively in Chapter 6 of your text than is possible for us to cover in our sessions.
- The text also highlights specialized outpatient treatment models and presents examples of programs that will be of interest to all who work in substance abuse settings.
- Treatment for substance abuse occurs more frequently in outpatient settings. Typically, treatment includes individual and group counseling, with referrals to appropriate community services.
- Until recently, there were few specialized approaches for people with COD in outpatient substance abuse treatment settings. However, as studies described in your text show, substance abuse programs can expect a substantial proportion of their clientele to have COD. Studies also show that the presence of a mental disorder often makes effective substance abuse treatment more difficult (Mueser et al. 2000; National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors 1999).
- This is why use of current best practices from the substance abuse treatment and mental health services fields in outpatient settings is so vital. Because outpatient treatment programs are available widely and serve the greatest number of clients (Committee on Opportunities in Drug Abuse Research 1996; Lamb et al. 1998), it is important that they use the best available treatment models to reach the greatest possible number of persons with COD.

Empirical Evidence of Effectiveness

- Evidence from the Drug Abuse Outcome Study (DATOS) dataset (Flynn et al. 1997) suggests that outpatient substance abuse treatment can lead to positive outcomes for certain clients with COD, even when treatment is not tailored specifically to their needs. Outpatient programs can be effective settings for treating substance abuse in clients with less serious mental disorders.
- Data show that substance abuse treatment outpatient programs can help clients, many with COD, who remain in treatment at least three (3) months (Hubbard et al. 1997; Simpson et al. 1997*a*). However, modifications designed to address issues faced even by those with less serious mental disorders can enhance treatment effectiveness and in some instances are essential.

5 minutes

OH #6B-5

Designing Outpatient Programs for Clients with COD

- Key topics related to the design of outpatient programs for clients with COD include:
  - Screening and assessment
  - Centralized intake
  - Reassessment
  - Referral and placement
  - Engagement
  - Discharge planning
  - Continuing care

Screening and Assessment

- As we've discussed in earlier modules, screening and assessment are used to make two (2) essential decisions:
  1. Is the individual stable enough to remain in an outpatient setting, or is more intense care indicated, warranting rapid referral to an appropriate alternative treatment?
  2. What services will the client need?
- To answer either question, staff must first determine the scope of the client's problems, including his physical and mental status, living situation, and the support he has available to face these problems.
- A thorough assessment should establish the client's:
  - Mental and physical status
  - Preexisting medical conditions or complications
  - Substance use history
  - Level of cognitive functioning
  - Prescription drug needs
  - Current mental status
  - Mental health history

- Whereas screening requires basic counseling skills, the consensus panel recommends that only specially trained or highly capable staff should perform assessments.

Centralized Intake

- A centralized intake team is a useful approach to screening and assessment, providing a common point of entry for many clients entering treatment. When applied in an agency with multiple programs, centralized intake reduces duplication of referral materials as well as assessment services.

Reassessment

- Once admitted to treatment, clients need regular reassessment as reductions in acute symptoms of mental distress and substance abuse may precipitate other changes.
- Periodic assessment will provide measures of client change and enable the provider to adjust service plans as the client progresses through treatment.

Referral and Placement

- Careful assessment will help to identify those clients who require more secure inpatient treatment settings (e.g., clients who are actively suicidal or homicidal), as well as those who require 24-hour medical monitoring, those who need detoxification, and those with serious substance use disorders who may require a period of abstinence or reduced use before they actively can engage in all treatment components.
  - TIP 29, *Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities* (CSAT 1998*e*), contains information on assessing physical and cognitive functioning that is relevant for all populations.
- It is important to view the client's placement in outpatient care in the context of continuity of care and the network of available providers and programs. Outpatient treatment programs may serve a variety of functions, including outreach/engagement, primary treatment, and continuing care.
- The consensus panel has mentioned that treatment providers should be careful not to place clients in a higher level of care (i.e., more intense) than is necessary. A client who might remain engaged in a less intense treatment environment may drop out in response to the demands of a more intense treatment program.

Engagement

- Clients with COD, especially those opposed to traditional treatment approaches and those who do not accept that they have COD, have particular difficulty committing to and maintaining treatment.
- Because clients with COD often have poor treatment engagement, it is particularly important that every effort be made to employ methods with the best prospects for increasing engagement.

9 minutes

Quick Tip Exercise

- On page 147 of your text, the consensus panel has included a text box with suggestions for *Improving Adherence of Clients with COD in Outpatient Settings*. This has been adapted from the work of Daley and Zuckoff. *(Allow participants to access page 147.)*

3 minutes

Small Group Work

- With a partner (or small group or individually) please review the suggestions on page 147.

  1. Which have been used in your agency?
  2. In your experience, what has been most successful in improving engagement for clients with COD?

OH #6B-6

6 minutes

Report Out

Trainer Note:

- Begin with Question 2. Have dyads (groups or individuals) share their responses.
- For Question 1, ask for a show of hands regarding use of the suggestions in the participants' agency(ies).
- Ask those with raised hands to share what their agency does and how successful it has been.
- Spend no more than six (6) minutes on the report out.
- Continue with script.

---

4 minutes

Designing Outpatient Programs for Clients with COD *continued*

Discharge Planning

OH #6B-7

- Discharge planning is important to maintain gains achieved through outpatient care. A carefully developed discharge plan, produced in collaboration with the client, will identify and match client needs with community resources, providing the supports needed to sustain the progress achieved in outpatient treatment.
- Clients with COD often need a range of services besides substance abuse treatment and mental health services. Prominent needs include housing and case management services to establish access to community health and social services. These should not be considered "ancillary," but key ingredients for clients' successful recovery.
- It is imperative that discharge planning for the client with COD ensures continuity of psychiatric assessment and medication management, without which client stability and recovery will be severely compromised.
- Relapse prevention interventions after outpatient treatment need to be modified so that the client can recognize symptoms of psychiatric or substance abuse relapse on her own and can call on a learned repertoire of symptom management techniques (e.g., self-monitoring, reporting to a "buddy," and group monitoring).
  - This also includes the ability to access assessment services rapidly, since the return of psychiatric symptoms can often trigger substance abuse relapse.
- Developing positive peer networks is another important facet of discharge planning for continuing care. The provider seeks to develop a support network for the client that involves family, community, recovery groups, friends, and significant others.

Continuing Care

- Continuing care and relapse prevention are especially important with this population, since people with COD are experiencing two (2) long-term conditions (i.e., mental disorder often is a cyclical, recurring illness; substance abuse is likewise a condition subject to relapse).

OH #6B-8

- Clients with COD often require long-term continuity of care that supports their progress, monitors their condition, and can respond to a return to substance use or a return of symptoms of mental disorder. Continuing care is both a process of post-treatment monitoring and a form of treatment itself. (In the present context, the term "continuing care" is used to describe the treatment options available to a client after leaving one program for another, less intense, program.)
- Upon leaving a program, clients with COD always should be encouraged to return if they need assistance with either disorder. A good continuing care plan will include steps for when and how to reconnect with services.

2 minutes

Implementing Outpatient Programs for Clients with COD

- The challenge of implementing outpatient programs for COD is to incorporate specific interventions for a particular subgroup of outpatient clients into the structure of generic services available for a typically heterogeneous population.
- Often this is best accomplished by establishing a separate track for COD consisting of the services described in the section on essential programming above.
- Accomplishing this often requires organizational change as substance abuse and mental health service agencies modify their mission to address the special needs of persons with COD.

Staffing and Training

- To accommodate clients with COD, standard outpatient drug treatment staffing should include both mental health specialists and psychiatric consultation and access to onsite or offsite psychopharmacologic consultation.
- An integrated model of treatment for clients with COD requires that each member of the treatment team has substantial competency in both fields. Both mental health and substance abuse treatment staff require training, cross-training, and on-the-job training to meet adequately the needs of clients with COD. All treatment staff should have sufficient understanding of substance use and mental disorders to implement the essential elements described in Module 6A.
- Key training areas for substance abuse treatment settings are listed at the bottom of page 149. *(Allow participants to access page 149.)*
- As discussed in Chapter 3 and in earlier sessions, staff trained exclusively either in mental health services or in substance abuse treatment models often have difficulty accepting the other's view of the person, the problem, and the approach to treatment. Cross-training and open discussion of differing viewpoints and challenging issues can help staff reach a common perspective and approach for the treatment of clients with COD within each agency or program setting.
- It is important that the staff function as an integrated team. Staff cooperation can often be fostered by cross-training, clinical team meetings and, most importantly, a treatment culture that stresses teamwork and collaboration.

5 minutes

OH #6B-9

Evaluating Outpatient Programs for Clients with COD

- Beginning on page 150, the text briefly outlines five (5) elements that are needed to design an evaluation process for an outpatient program. Evaluation can answer staff and administrator questions on the effectiveness or outcome of treatment for persons with COD. Evaluation data can then be used to improve programs.
- The five (5) evaluation process elements are:

Define the operational goals of the program in terms of the client behaviors for which change is sought.

- Programs may define their goals for client change narrowly in terms of reductions in alcohol and drug use and crime only. Or they can define them more broadly, to include reductions in psychological symptoms, homelessness, unemployment, and so on.
- ***ASK***—How does your agency or program define its goals for client change for purposes of evaluation? In other words, what standard has your agency chosen to measure the effectiveness of your collective efforts? *(Solicit participant responses.)*

Decide who the study clients will be and devise a plan for selecting or sampling those clients.

- Depending on the rate of client entry into a program and the number of clients sought for the outcome study (typically at least 35), a program may select every client presenting to treatment over the course of the designated time period or may sample systematically (e.g., taking every third client) or randomly (e.g., using a coin toss).
  - It is important to use a system that avoids bias (i.e., selection of clients who, for one reason or another, are believed to be more likely to respond particularly well or particularly poorly to the treatment program).

Locate and/or develop instruments that can be used to assess client functioning in the areas of concern for outcome.

- ***ASK***—What kinds of instruments does your agency use to measure how well you are meeting the goals you've set for your clients and for your program?

Develop a plan for data collection.

Develop a plan for data analysis and reporting.

- Manuals designed to assist treatment programs with outcome studies are available from CSAT and NIDA. These are also described in this section of your text.

2 minutes

Sustaining Outpatient Programs for Clients with COD

- Two (2) important issues for substance abuse treatment agencies that wish to sustain an outpatient program for clients with COD are: 1) funding and 2) organizational change.

Financing Integrated Treatment

- Funding resources for substance abuse treatment remain significantly lower per client than those available for mental health services. Models demonstrating positive results originating in the mental health field often are too expensive to be implemented fully in more fiscally limited substance abuse treatment settings.
- Starting on page 151, the consensus panel offers several recommendations to help finance integrated treatment. *(Allow participants to access page 151.)*
  - An obvious solution to funding shortfalls is to access funding streams that support mental health services.
  - Such funding may be based on demonstrating the nature, severity, and extent of co-occurring mental disorders among clients, with documentation of the full range of diagnosed disabilities of clients with COD.
  - Arapahoe House is an example of an agency that is able to provide integrated treatment. Arapahoe House is a nonprofit corporation located near Denver, Colorado. It is the State's largest provider of substance abuse treatment services. In addition, Arapahoe House is a licensed mental health clinic and strives to provide fully integrated services for clients with COD in all of its treatment programs. Because all Arapahoe House programs are designed to provide integrated treatment for clients with COD, the agency employs several psychiatrists on contract in both the residential and outpatient settings (refer to text box on page 154).

Planning for Organizational Change

- Organizational change is another matter agencies need to plan for. Changing the processes and approaches in an organization, such as adding and integrating mental health staff into the substance abuse setting, can be challenging.
- Substance abuse treatment agencies should plan for any organizational changes needed to introduce new or altered approaches into program settings.
- Change strategies should be grounded in sound organizational change principles and may be effective in helping all parties understand, accept, and adjust to changes.
- A recommended source book is *The Change Book: A Blueprint for Technology Transfer* (Addiction Technology Transfer Center National Office 2000).

4 minutes

Examples of Outpatient Programs

- The text also describes in detail two (2) specialized treatment models for clients with COD: 1) Assertive Community Treatment (ACT), and 2) Intensive Case Management (ICM). The text selected these specialized models because the framework, model, and methods of each are articulated clearly, both have been disseminated widely and applied, and each has support from a body of empirical evidence.
- Although ACT and ICM can be thought of as similar in several features they function differently from each other with regard to goals, operational characteristics, and the nature and extent of the activities and interventions they provide. Therefore, each is described separately.
- In this session, you will have the opportunity to look over some of this information very briefly. We hope you will follow this introduction with a more careful reading and application of this information.

Assertive Community Treatment (ACT)

- Description of the ACT begins on page 152.

Trainer Note:

- Allow participants to access page 152.
- Have participants follow page by page, as you talk about what the text includes on ACT.

- The text provides a description of:
  - The history of ACT (p. 152)
  - The program model (p. 153)
  - Activities and interventions (p. 153)
  - Key modifications when working with clients with COD (p. 155)
  - The populations that can be served with this model (p. 155)
  - Empirical evidence validating the effectiveness of the model is also included (p. 156)

OH #6B-10

- The text box at the top of page 156 outlines the *Nine (9) Essential Features of ACT. (Allow participants to access page 156.)*
- The *Nine (9) Essential Features of ACT* are:

1. Services provided in the community, most frequently in the client's living environment
2. Assertive engagement with active outreach
3. High intensity of services
4. Small caseloads
5. Continuous 24-hour responsibility
6. Team approach (the full team takes responsibility for all clients on the caseload)
7. Multidisciplinary team, reflecting integration of services
8. Close work with support systems
9. Continuity of staffing

Empirical Evidence for ACT—*Optional*

Trainer Note:

- If time allows, ask participants turn to page 156. Allow participants time to access the page.
- Highlight for participants the general consensus of research to date regarding the ACT model is that it is a recommended treatment model for clients with COD, especially those with serious mental disorders.

- The ACT model has been researched widely as a program for providing services to people who are chronically mentally ill. The general consensus of research to date is that the ACT model for mental disorders is effective in reducing hospital recidivism and, less consistently, in improving other client outcomes (Drake et al. 1998*a*; Wingerson and Ries 1999).

- Randomized trials comparing clients with COD assigned to ACT programs with similar clients assigned to standard case management programs have demonstrated better outcomes for ACT (Drake et al. 1998*a*; Morse et al. 1997; Wingerson and Ries 1999). It is important to note that ACT has not been effective in reducing substance use when the substance use services were brokered to other providers and not provided directly by the ACT team (Morse et al. 1997).
- Researchers also considered the cost-effectiveness of these interventions concluding that ACT has better client outcomes at no greater cost and is, therefore, more cost-effective than brokered case management (Wolff et al. 1997).
- Other studies of ACT were less consistent in demonstrating improvement of ACT over other interventions (e.g., Lehman et al. 1998). Furthermore, clients in high-fidelity ACT programs show greater reductions in alcohol and drug use and attain higher rates of remissions in substance use disorder than clients in low-fidelity programs (McHugo et al. 1999).

Intensive Case Management (ICM)

- Description of the ICM model begins on page 157.

Trainer Note:

- Allow participants to access page 157.
- Have participants follow page by page, as you talk about what the text includes on ICM.

- Again, the text provides a description of:
  - The history of ICM (p. 157)
  - The program model (p. 157)
  - Activities and interventions (p. 158)
  - Key modifications when working with clients with COD (p. 158)
  - Empirical evidence (p. 158)

OH #6B-11

- Please turn to page 158. *(Allow participants to access page 158.)*
- Examples of ICM activities and interventions include:
  - Engaging the client in an alliance to facilitate the process and connecting the client with community based treatment programs
  - Assessing needs, identifying barriers to treatment, and facilitating access to treatment
  - Offering practical assistance in life management and facilitating linkages with support services in the community
  - Making referrals to treatment programs and services provided by others in the community
  - Advocating for the client with treatment providers and service delivery systems
  - Monitoring progress
  - Providing counseling and support to help the client maintain stability in the community
  - Crisis intervention
  - Assisting in integrating treatment services by facilitating communication between service providers

Empirical Evidence—*Optional*

Trainer Note:

- If time allows, ask participants turn to page 158. Allow participants time to access the page.
- Highlight the empirical evidence for ICM. Use this section to point out that while different program models may be effective and recommended, they may not have the same weight of research evidence for effectiveness. In the case of ICM, this is because empirical study of ICM for COD has not been as extensive or as clarifying as the research on using ACT for COD.

- The empirical study of ICM for COD is not as extensive or as clarifying as the research on ACT. However, some studies do provide empirical support.
- ICM has been shown to be effective in engaging and retaining clients with COD in outpatient services and to reduce rates of hospitalization (Morse et al. 1992).
- Further, treatments combining substance abuse counseling with ICM services have been found to reduce substance use behaviors for this population in terms of days of drug use, remission from alcohol use, and reduced consequences of substance use (Bartels et al. 1995; Drake et al. 1993, 1997; Godley et al. 1994).

10 minutes

TIP Exercise—ACT / ICM Grid

- The section concludes with a comparison of similarities and contrast of differences between the two (2) models. Also included are recommendations for using the ACT and ICM models in substance abuse treatment settings with clients who have COD.

5 minutes

Small Group Work

OH #6B-12

Trainer Note:

- Make sure all small groups have a blank grid (see Handout section).
- Assign half the groups to examine the ACT model, and the other half to examine the ICM model.
- Explain that they are to scan through the TIP information on these models and complete their grids.
- Suggest that division of labor within the group may be more efficient for this activity.
- Add some interest by providing a "prize" to the group accurately completing their grid first.

5 minutes

Report Out

Trainer Note:

- Examine each of the characteristics by having one ACT group share their answer, then asking one ICM group to share their answer. Then ask if any had markedly different responses.
- Keep the pace crisp and the responses brief.
- Allow no more than 5 minutes for the report out.
- Supplement responses using the grid below, if necessary.

ACT / ICM Grid-Compare and Contrast

Characteristics	ACT	ICM
Intensity Level	More intensive	Less intensive
Emphasis	Developing a therapeutic alliance with the client and delivery of service components in the client's home, on the street, or in program offices (based on the client's preference).	Brokering community-based services for the client.
Hours of Service	Provide services 16 hours a day on weekdays, 8 hours a day on weekends, plus on-call crisis intervention, including visits to the client's home at any time, day or night, with the capacity to make multiple visits to a client on any given day.	Fewer hours of direct treatment, may include 24-hour crisis intervention.
Caseload Ratio	Caseloads usually are 12:1	Caseloads of 15:1-25:1
Team Characteristics	The ACT multidisciplinary team has shared responsibility for the entire defined caseload of clients and meets frequently (ideally, teams meet daily) to ensure that all members are fully up-to-date on clinical issues.	ICM team functioning is not as defined and cohesion is not necessarily a focus of team functioning; the ICM team can operate as a loose federation of independent case managers, or as a cohesive unit in a manner similar to ACT.

1 minute

Wrap up

Trainer Note:

- The trainer closes the module with a brief summary statement.

- Our focus in this module has been on outpatient treatment settings that serve clients with COD. We examined issues related to designing, implementing, evaluating and sustaining these programs. We have also looked at two (2) specialized treatment models suggested by the TIP consensus panel, the Assertive Community Treatment (ACT) model, and the Intensive Case Management (ICM) model.

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

Module 6B
SPECIALIZED TREATMENT MODEL GRID

Using the information in the TIP text, complete the grid for the model you have been assigned (ACT or ICM).

Characteristics	Model: _____
Intensity Level	
Emphasis	
Hours of Service	
Caseload Ratio	
Team Characteristics	

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 6B

Introduction

Traditional Settings and Models:
Outpatient Substance Abuse Treatment Programs for Clients with COD

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Chapter 6 Modules

- Module 6A
  - Essential Programming & General Considerations for Treatment of Clients with COD
- **Module 6B**
  - Outpatient Substance Abuse Treatment Programs for Clients with COD
- Module 6C
  - Residential Substance Abuse Treatment Programs for Clients with COD

7 Essential Elements & General Considerations

- Working in groups
- Involving clients in treatment and program design
- Family education

1. Screening, assessment, & referral for persons with COD
2. Physical & mental health consultation
3. Prescribing onsite psychiatrist
4. Medication & medication monitoring
5. Psychoeducational classes
6. Double trouble groups (onsite)
7. Dual recovery self-help groups (offsite)

In This Module . . .

- **Outpatient Substance Abuse Treatment Programs for Clients with COD**
  - Designing
  - Implementing
  - Evaluating
  - Sustaining
  - Examples of programs

Designing Outpatient Programs for Clients with COD

- Screening and assessment
- Centralized intake
- Reassessment
- Referral and Placement
- Engagement
- Discharge Planning
- Continuing Care

Quick TIP Exercise

Review "Improving Adherence of Clients with COD in Outpatient Settings" (p. 147).

1. Which have been used in your agency?

2. In your experience, what has been most successful in improving engagement in treatment for clients with COD?

(3 minutes)

Discharge Planning

- Housing
- Case management services
- Medication management
- Relapse prevention
- Positive peer networks
  - Mutual self help groups
- Advocacy involvement

Continuing Care

Clients with COD often require long-term continuity of care that:

- Supports their progress
- Monitors their condition
- Responds to a return to substance use or return to symptoms of mental disorder
- Describes steps for when & how to reconnect with services

Evaluating Outpatient Programs for Clients with COD

1. Define operational goals in terms of the client behaviors
2. Decide on study clients and sampling
3. Locate and/or develop instruments
4. Develop plan for data collection
5. Develop plan for analysis and reporting

Nine Essential Features of ACT

1. Services provided in the community
2. Assertive engagement with active outreach
3. High intensity of services
4. Small caseloads
5. Continuous 24-hour responsibility
6. Team approach
7. Multidisciplinary team, reflecting integration of services
8. Close work with support systems
9. Continuity of staffing

Source: Drake et al. 1998a.

ICM Activities and Interventions

- Engage client to facilitate process & connect with community-based treatment programs
- Assess needs, identify barriers & facilitate access to treatment
- Offer practical assistance & facilitate linkages
- Make referrals
- Advocate for client
- Monitor progress
- Provide counseling & support
- Crisis intervention
- Assist in facilitating communication between service providers

TIP Exercise—Act / ICM Grid

- In small groups, use the information in your TIP text to complete the handout grid for the model you have been assigned (ACT or ICM).

(5 minutes)

MODULE 6C: Traditional Settings and Models: Residential Substance Abuse Treatment Programs for Clients with COD

Objectives

- Chapter 6 of the TIP examines two (2) questions: 1) What happens to clients with COD who enter traditional substance abuse settings? and 2) How can programs provide the best possible services to these people? The chapter's material has been divided into three (3) modules:
  - *Module 6A* examines essential programming recommendations and general considerations for treatment of clients with COD.
  - *Module 6B** explores outpatient substance abuse treatment programs for clients with COD paying particular attention to issues related to designing, implementing, evaluating and sustaining such programs.
  - ***Module 6C**** explores residential substance abuse treatment programs for clients with COD paying particular attention to issues related to designing, implementing, evaluating and sustaining such programs.

* The trainer may opt to present either 6B or 6C depending on which is most appropriate to the participants' needs.

Trainer Note:

- The following trainer notes are for Module 6C only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 6C.1-6C.15
- Newsprint sheets and markers for small group work
- Kitchen timer
- Markers and Post-It notes for participants to use on their TIP texts
- Masking tape to post newsprint on wall

Module Design

- Module 6C is a blend of lecture, group work/peer teaching, dyadic discussion, and constant interaction with the TIP text. Depending on participant knowledge and experience, the module can be used:
  - As general introductory information on key issues related to residential care for clients with COD
  - As a guide by those considering or planning a residential substance abuse treatment program for clients with COD
  - As a standard against which staff already working in a residential substance abuse treatment programs for clients with COD can examine their program
- Trainers will need to tailor the presentation accordingly and plan which sections of the script to emphasize and which to touch on briefly or delete if time becomes a consideration.

Time Management

- The suggested time allotments will depend on the audience's needs and how the trainer adjusts the script to meet those needs. The trainer will have to carefully time tasks related to both the TIP Exercise and the TIP Quick Exercise as these can easily go over the time limits. The trainer must consider prior to the session what adjustments to make to the script, given participant needs, if time should become a concern.

Seating

- Formal small group discussion, which occurs early in the module, is designed for small groups of 3-5 participants. At least four (4) small groups are required for the initial TIP Exercise. If the total number of participants is small then dyads can be used instead of small groups. Should the trainer prefer participants to work with someone other than the persons they are likely to sit with initially, this re-seating should be carried out quickly before the module begins, perhaps as part of a quick ice-breaker or warm-up activity.

Suggested Timetable for Module 6C	
Introduction ■ Reconvening and Review of Module 6A and 6B ■ In This Module	5 minutes
Residential Substance Abuse Programs for Clients with COD ■ Background and Effectiveness ■ Prevalence ■ Empirical Evidence of Effectiveness	4 minutes
Designing Residential Programs for Clients with COD ■ TIP Exercise—Design – Set up—*1 minute* – Group work—*8 minutes* ■ Report Out / Peer Teaching—*8 minutes* ■ Intake ■ Assessment ■ Engagement ■ Continuing Care ■ Discharge Planning	17 minutes
Implementing Residential Programs for Clients with COD ■ Staffing ■ Training—Initial Training ■ Quick TIP Exercise—Training – Dyad Work—*2 minutes* – Process—*5 minutes* ■ Training—Ongoing Training and Technical Assistance	10 minutes
Evaluating Residential Programs for Clients with COD	1 minute
Sustaining Residential Programs for Clients with COD	1 minute
Therapeutic Communities ■ Modified Therapeutic Communities for Clients with COD	5 minutes
Wrap up	2 minutes
TOTAL	**45 minutes**

5 minutes

OH #6C-1

Introduction

Reconvening and Review of Modules 6A and 6B

Trainer Note:

- This section reviews how Chapter 6 content is divided among Modules 6A, 6B and 6C. It briefly summarizes the main topics of Modules 6A and 6B and introduces Module 6C.
- Check that everyone has a copy of the TIP. Lend copies or have people share.
- Review Module 6A and 6B sessions. (If Module 6B has not been presented, review Module 6A and then proceed to the "In This Module" section of the script below).

OH #6C-2

OH #6C-3

- Chapter 6 in your text takes a programmatic perspective. The chapter examines two (2) questions: 1) What happens to clients with COD who enter traditional substance abuse settings? and 2) How can programs provide the best possible services to these people?
- In Module 6A, we examined the essential programming elements in COD programming for substance abuse treatment agencies that treat clients with COD. These elements are applicable in both residential and outpatient programs. The module also addressed some general programmatic considerations for treatment of clients with COD, including modification to group work.
- In Module 6B, we also took a closer look at outpatient settings paying particular attention to issues related to:
  - Designing
  - Implementing
  - Evaluating
  - Sustaining outpatient substance abuse treatment programs for clients with COD
- Finally, we examined two (2) outpatient models: the Assertive Community Treatment (ACT) and the Intensive Case Management (ICM) models.

In This Module . . .

OH #6C-4

- Module 6C takes a similar approach to the examination of residential substance abuse treatment programs for clients with COD. Again, we will be talking about issues related to:
  - Designing
  - Implementing
  - Evaluating
  - Sustaining treatment programs for clients with COD, only this time our focus is residential substance abuse treatment settings

Trainer Note:

- If the trainer is not familiar with the practice settings of all of the participants:
- ***ASK***—How many of you work or have worked in residential substance abuse treatment settings? Was there special programming for clients with COD? (If yes...) Can you briefly describe it?
- Based on participants' responses, tailor the presentation to make use of their past experience in residential settings by having them compare practices in those settings with recommendations presented, or provide examples of points discussed.

- In this chapter, the text uses the Modified Therapeutic Community or MTC as an example of a residential model. The MTC adapts the principles and methods of the TC or Therapeutic Community model to the circumstances of the client with COD.
- Although the MTC is used as a frame of reference in some of the discussions of program design and development, most of these observations are also applicable to other residential programs that might be developed for COD.

- At the end of the chapter, the text provides several examples of existing residential programs that have been adapted for clients with COD. On pages 176-179, your text provides descriptions of various TC or MTC programs that are part of Gauedenzia, Inc. Gaudenzia, Inc. is the largest nonprofit provider of substance abuse services in Pennsylvania. *(Allow participants to access page 176.)*

- Because a variety of other residential models have also been adapted for clients with COD, the text includes two (2) other representative models. Starting on page 180, these include the Na'nizhoozi model in the Southwest, which is designed for American Indians with alcohol problems, and the Foundations Associates model of Tennessee, which integrates short-term residential treatment with outpatient services. *(Allow participants to access page 180.)*

- All of these topics related to residential programs are covered far more extensively in Chapter 6 of your text than is possible for us to cover in our sessions, so please familiarize yourself with this information at your convenience.

4 minutes

Residential Substance Abuse Treatment Programs for Clients with COD

Background and Effectiveness

- Information on residential programs begins on page 161 of your text with some general descriptive background. Please turn to page 161. *(Allow participants to access page 161.)*
- Residential setting can take a variety of forms, including:
  - Long-term (12 months or more) residential treatment facilities
  - Criminal justice-based programs
  - Halfway houses
  - Short-term residential programs
- The long-term residential substance abuse treatment facility is the primary treatment site and the focus of this section of the TIP.
- Historically, residential substance abuse treatment facilities have provided treatment to clients with more serious and active substance use disorders but with less serious mental illness (SMI).

Prevalence

- As mentioned previously, an increasing proportion of clients in many substance abuse treatment settings suffer from mental disorders (De Leon 1989; Rounsaville et al. 1982*a*).
- Research shows that in the year prior to admission to treatment, clients in long-term residential care reported the highest rate of past suicidal thoughts or attempts as compared to outpatient drug free and outpatient methadone treatment. This evidence points to the need for a programmatic response to the problems posed by those with COD who enter residential treatment settings.

Empirical Evidence of Effectiveness

- Research studies have established the effectiveness of residential substance abuse treatment (Fletcher et al. 1997; Hubbard et al. 1989). Your text discusses evidence from a number of large-scale, longitudinal, multisite treatment studies showing that residential substance abuse treatment results in significant improvement in drug use, crime, and employment.
- However, an important relationship exists between the effectiveness of treatment and the amount of time a person is in treatment. Studies have shown that those who remain in treatment for at least three (3) months have more favorable outcomes. Therefore, a critical retention threshold of at least 90 days has been established for residential programs (Condelli and Hubbard 1994; Simpson et al. 1997*b*, 1999).
  - Legal pressure and internal motivation among clients in residential programs have been associated with retention beyond the 90-day threshold (Knight et al. 2000). This relationship between legal pressure and retention supports practices that encourage court referrals to residential treatment (Hiller et al. 1998).

17 minutes

Designing Residential Programs for Clients with COD

Trainer Note:

- Material from his section is covered using the TIP Exercise—Design. Participants are divided into at least four (4) small groups of 3-5 people. Each group is assigned to explore one (1) of the design topics in the text: Intake, Assessment, Engagement (including the Figure on page 165), and Continuing Care and Discharge Planning. If there are more than four (4) groups, duplicate assignments.
- The groups will spend eight (8) minutes preparing to teach their topic to the rest of the group. They will illustrate their presentation by assessing which relevant procedures in their program already meet the consensus guidelines for COD, and which would need to change to comply with the text.
- Each group will then spend two (2) minutes "teaching" their topic to the larger group. For duplicate assignments, share the report-out time with one group taking the lead and the other briefly adding any group findings that were different.
- Slides and scripting are included for each of the topics should the trainer wish to display the overheads during reports, supplement reports, or answer questions.

OH #6C-5

- Starting on page 162, the text addresses key topics related to the design of residential programs for clients with COD. *(Allow participants to access page 162.)*

- These key topics related to the design of residential programs for clients with COD include:
  - Intake
  - Assessment
  - Engagement
  - Continuing Care
  - Discharge Planning
- We are going to take a closer look at the information for each of these topics in groups:
  - Group 1 will focus on the section on Intake.
  - Group 2 will focus on the Assessment section.
  - Group 3 will focus on Engagement. This includes the Figure on page 165.
  - Group 4 will examine both Continuing Care and Discharge Planning.

Trainer Note:

- Make assignments to four (4) groups:
  - Intake
  - Assessment
  - Engagement (includes Figure on page 165)
  - Continuing Care and Discharge Planning

9 minutes

OH #6C-6

TIP Exercise—Design

- Now that your group has been assigned a topic:

  1. Please read what the text recommends relevant to your topic.
  2. As you read, think about how these activities are currently conducted in the programs where you work (or have worked).
  3. Finally, I would like each group to teach this material briefly to the larger group. To illustrate your topic, describe what could stay the same and what would need to change in your program to meet the text's recommendations for COD programs.

- You will have eight (8) minutes, and then we will report out.

Trainer Note:

- If participants work in a setting that is planning a program for COD clients, participants can compare planned procedures to the text's recommendations.
- Set timer for eight (8) minutes.
- Give one (1) minute warning. Then call time.

---

8 minutes

Report Out / Peer Teaching

Trainer Note:

- Allow each group two (2) minutes to report out.
- Below are overheads and comments for each of the topics should the trainer wish to display the overheads during reports, supplement reports, or answer questions.
- Congratulate or applaud each group when finished.
- When reporting is complete, resume session with the "Implementing Residential Programs for Clients with COD" section on page 18.

- Each group will have two (2) minutes to explain your topic and give illustrations based on your workplace. *(Begin reports with Group 1 and follow in order with remaining groups until all have reported out.)*

Intake

OH #6C-7

- On page 162, the text discusses four (4) interrelated steps relevant to the intake process for clients with COD:

  1. Written referral

     – Referral information from other programs may include a psychosocial history and a physical examination as well as the client's:

       • Psychiatric diagnosis

       • History

       • Current level of mental functioning

       • Medical status

       • Assessment of functional level

  2. Intake interview

     – A counselor or clinical team conducts the intake interview at the program site. Screening instruments such as those described in Chapter 4 of your text can be used.

     – The referral material is reviewed, and each client is interviewed to determine if the referral is appropriate in terms of the history of mental and substance abuse problems.

     – The client's residential and treatment history is reviewed. The client's motivation and readiness for change are assessed as well as the client's willingness to accept the current placement as part of the recovery process.

  3. Program review

     – Each client should receive a complete description of the program and a tour of the facility including:

       • A description of the daily operation of the program in terms of groups, activities, and responsibilities.

       • A tour of the physical site (including sleeping arrangements and communal areas).

       • An introduction to some of the clients who are already enrolled in the program.

4. Team meeting

   – At the end of the intake interview and program review, the team meets with the client to arrive at a decision concerning whether the referred client should be admitted to the program.

Assessment Areas

OH #6C-8

■ Once accepted into the program, the client goes through an assessment process that should include five (5) areas:

1. Substance abuse evaluation

   – This includes assessing age of first use, primary drugs used, patterns of drug and alcohol use, and treatment episodes.

2. Mental health evaluation

   – Upon placement in a residential facility, it is desirable to have a psychiatrist, psychologist, or other qualified mental health professional evaluate each client's mental status, cognitive functioning, diagnosis, medication requirements, and the need for individual mental health services.

3. Health and medical evaluation

   – Each client should receive a complete medical evaluation within 30 days of entry into the program. Referral information contains the results of recent medical examinations required for placement.

     • All outstanding medical, dental, and other health issues, including infectious diseases, especially HIV and hepatitis, should be addressed early in the program through affiliation agreements with licensed medical facilities.

4. Entitlements

   – The counselor should assess the status of each client's entitlements (e.g., Supplemental Security Income [SSI], Medicaid, etc.) and assist clients in completing all necessary paperwork to ensure maximum benefits.

5. Client status

   – Staff members assess clients' status as they enter treatment, including personal strengths, goals, family, and social supports. A key assessment weighs the client's readiness and motivation for change.

Engagement

- The critical issue for clients with COD is engaging them in treatment so that they can make use of the available services.
- The more engaged a client is, the better the odds of that client remaining in treatment. As mentioned earlier, retaining a client in the program for 90 or more days can have a significant effect on his or her treatment outcomes.
- The program must meet essential needs and ensure psychiatric stabilization. The consensus panel suggests that residential treatment programs can accomplish this by offering a wide range of services that include both targeted services for mental disorders and substance abuse and a variety of other "wraparound" services including medical, social, and work-related activities.
- On page 165, in Figure 6-1, the text describes interventions to promote engagement. *(Allow participants to access Figure 6-1 on page 165.)*
- These include therapeutic community-oriented methods described in other studies (Items 1, 3, 5-7), as well as strategies employed and found clinically useful in non-TC programs (Items 2 and 4). This approach holds promise for expanding treatment protocols for TC and many non-TC programs to permit wider treatment applicability.

Figure 6-1
Engagement Interventions

Item	Element	Description
1	Client Assistance Counseling	Emphasizes client responsibility, coaching and guiding the client, and using the client's senior peers to provide assistance
2	Medication	Begins with mental health assessment and medication prescription, then monitors for medication adherence, side effects, and effectiveness
3	Active Outreach and Continuous Orientation	Builds relationships and enhances program compliance and acceptance through multiple staff contacts
4	Token Economy	Awards points (redeemable for tangible rewards such as phone cards, candy, toiletries) for positive behaviors including medication adherence, abstinence, attendance at program activities, follow-through on referrals, completing assignments, and various other activities essential to the development of commitment
5	Pioneers—Creating a Positive Peer Culture	Facilitates program launch by forming a seedling group of selected residents (pioneers) to transmit the peer mutual self-help culture and to encourage newly admitted clients to make full use of the program
6	Client Action Plan	Formulated by clients and staff to specify, monitor, and document client short-term goals under the premise that substantial accomplishments are achieved by attaining smaller objectives
7	Preparation for Housing	Entitlements are obtained—a Section 8 application for housing is filed, available treatment and housing options are explored, work readiness skills are developed, and household management skills are taught

Source: Adapted from Sacks et al. 2002.

Continuing Care

OH #6C-9

- Returning to life in the community after residential placement is a major undertaking for clients with COD. Relapse is an ever-present danger. The long-term nature of mental disorders and substance abuse requires continuity of care for at least 24 months (see, e.g., Drake et al. 1996*b*, 1998*b*).
- The goals of continuing care programming are:
  - Sustaining abstinence
  - Continuing recovery
  - Mastering community living
  - Developing vocational skills
  - Obtaining gainful employment
  - Deepening psychological understanding
  - Increasing assumption of responsibility
  - Resolving family difficulties
  - Consolidating changes in values and identity
- The key services to facilitate these goals are:
  - Life skills education
  - Relapse prevention
  - 12-Step or double trouble groups
  - Case management (especially for housing)
  - Vocational training and employment

OH #6C-10

Discharge Planning

- Discharge planning follows many of the same procedures discussed in the section on outpatient treatment on pages 147 and 148 of the text. These are summarized on the slide. However, there are several other important points for residential programs:
  - Discharge planning begins upon entry into the program.
  - The latter phases of residential placement should be devoted to developing with the client a specific discharge plan and beginning to follow some of its features.
  - Discharge planning often involves continuing in treatment as part of continuity of care.
  - Obtaining housing, where needed, is an integral part of discharge planning.

10 minutes

Implementing Residential Programs for Clients with COD

Trainer Note:

- Following a brief review of the text's information on staffing and training, this section includes a Quick TIP Exercise. Working in dyads, participants will spend two (2) minutes reviewing the questions in the left column of Figure 6-3 (pages 167-168) and substituting the treatment model used in their workplace for the word "TC" (if TC is not the model used). Participants will then consider: a) Which questions can they answer easily? and b) Which answers are they less sure of?
- The trainer can then ask a couple of dyads to share their results, or call out the questions and ask for a show of hands. If appropriate, the trainer may ask those who feel sure of their answers to share them.
- The trainer will guide the group in processing what the overall results indicate regarding training needs and how this affects treatment outcomes. How does this staff knowledge and skill (or lack of it) affect treatment? How does it affect fidelity to program goals and methods? This discussion is meant to enhance awareness. The trainer should set a positive tone by guiding the comments toward constructive, thoughtful reflections and away from public critique of any individual's or program's training deficiencies.

CC

OH #6C-11

Staffing

- In programs for clients with COD, the staff should consist of a substantial proportion of both mental health and substance abuse treatment providers. Both recovering and nonrecovering staff should be included. The staff must also be culturally competent with regard to the population in treatment.
- A typical 25-bed residential program should consist of about 15 staff, as follows:
  - Program director (preferably with an advanced degree in the human service field or with at least five (5) years' experience in substance abuse treatment, including at least three (3) years of supervisory experience)
  - Secretary
  - Program supervisor (preferably with a bachelor's degree)
  - 10 line staff (with high school diplomas or associate's degrees)
  - Clinical coordinator
  - Nurse practitioner (half-time)
  - Entitlements counselor (half-time)
  - Vocational rehabilitation counselor (half-time)
  - Consultive and/or collaborative arrangements for medical, psychiatric, and psychological input or care
- The critical position is the ***clinical coordinator*** who will direct program implementation.
- The optimal staffing ratio is 3:1 for morning, 3:1 for afternoon, and 8:1 for night shifts.

Training

Initial training

- Implementing a new initiative requires both initial training and continuing technical assistance.
- Learning should be both a didactic and experiential activity.

- On page 167, Figure 6-3 provides a summary of the initial training for an MTC as an example. This training is conducted at the program site for five (5) days before program launch. The training provides a model of structure and process that can be applied in other TC and non-TC settings. *(Allow participants to access page 167.)*
- The curriculum includes special training in the assessment and treatment of clients with COD as well as in the key modifications of the TC for clients with COD (see Figure 6-3).
- Once established, the flagship program becomes the model for subsequent experiential training.

Quick Tip Exercise—Training

OH #6C-12

- We are going to spend two (2) minutes on a Quick Tip Exercise.
- With your partner, I would like you to look over the questions in Figure 6-3 (pages 167-168) again.
- For each question in the left column, substitute the treatment model used in your workplace for the word "TC" (if TC is not the model used at your workplace).
- Then consider, which questions can you answer easily for the model(s) you use?
- Which answers are you less sure of?

Trainer Note:

- Set timer for two (2) minutes. Call time.
- Quickly review results by asking a couple of dyads to share their results, or by calling out the questions and using a show of hands.
- If appropriate, call on those who feel sure of their answers.
- Briefly process what the results might indicate regarding training needs and treatment outcomes.
- How does this staff knowledge and skill (or lack of it) affect treatment? How does it affect fidelity to program goals and methods?
- Spend no more than five (5) minutes processing responses. Then, resume lecture on Training by moving on to the next topic.

Ongoing training and technical assistance

- Training and technical assistance take place in the field; both are direct and immediate. Staff members learn exactly how to carry out program activities by participating in the activities.
  - In the case of TCs, technical assistance begins with a discussion of TC methods over a period of time (usually several weeks) before implementation, followed by active illustration during the initiation period (several weeks to several months).
  - Supervisors hold briefing and debriefing sessions before and after each group activity, a process that continues for several months.
  - As staff members begin to lead new activities, technical assistance staff members provide guidance for a period of several weeks. Once staff demonstrate competency, quarterly reviews ensure continued staff competency and fidelity of program elements to TC principles and methods.

1 minute

Evaluating Residential Programs for Clients with COD

Trainer Note:

- This information is presented very briefly and refers participants to the discussion on evaluation in Module 6B.

OH #6C-13

- The model for evaluation outlined on pages 150-151 in your text's section on outpatient services (which we reviewed in Module 6B) can also be applied to residential settings. *(Allow participants to access pages 150-151 if Module 6B has not been previously presented.)*
- The efficacy of programs can be evaluated by determining change from pre- to post-treatment on basic measures of substance abuse and psychological functioning.
- The section on Evaluation of Residential Programs starting on page 169 includes a variety of useful evaluation suggestions for use by administrators to improve their programs. *(Allow participants to access page 169.)*

1 minute

Sustaining Residential Programs for Clients with COD

- One important vehicle for sustaining the residential program is through the development of a Continuous Quality Improvement (CQI) plan described in your text on page 170. *(Allow participants to access page 170.)*
- The goal of CQI is to assess and ensure that the program meets established standards. It is a participatory process led by internal program staff with consultation from experts who use both quantitative and qualitative information to monitor and review program status and to develop action plans for program improvements and refinements.

OH #6C-14

- For quality control, the CQI staff uses:
  - Observation
  - Key informant interviews
  - Resident focus groups
  - Standardized instruments
  - Staff review
- CQI is a management plan for sustaining program quality, for ensuring that programs are responsive to client needs, and for maintaining performance standards.

5 minutes

Therapeutic Communities

Trainer Note:

- Information on the TC model of treatment will need to be tailored to match participant familiarity with the model. The script concentrates on a general overview including goals, views, and interventions. If participants are already familiar with the principles and methods of TC, then dedicate more time to the section on modifications for TC (including the text box on confrontation on page 169) and on the examples of MTC programs on pages 176-178.

- Much of the remainder of the chapter explores the Therapeutic Community model and the Modified Therapeutic Community for clients with COD.
- ***ASK***—How many are familiar with the Therapeutic Community model or the Modified TC? Can you briefly describe your experience for us?
- The effectiveness of TCs in reducing drug use and criminality has been well documented in a number of program-based and multisite evaluations described in your text.
  - Short- and long-term follow-up studies show significant decreases in alcohol and illicit drug use, reduced criminality, improved psychological functioning, and increased employment (Condelli and Hubbard 1994; De Leon 1984; Hubbard et al. 1997; Simpson and Sells 1982).
  - In general, positive outcomes are related directly to increased length of stay in treatment (De Leon 1984; Hubbard et al. 1984; Simpson and Sells 1982).

OH #6C-15

- The goals of the TC are to:
  - Promote abstinence from alcohol and illicit drug use
  - Decrease antisocial behavior
  - Effect a global change in lifestyle, including attitudes and values
- The TC views drug abuse as a disorder of the whole person, reflecting problems in conduct, attitudes, moods, values, and emotional management.
- Treatment focuses on drug abstinence, coupled with social and psychological change that requires a multidimensional effort, involving intensive mutual self-help typically in a residential setting.

Modified Therapeutic Communities for Clients with COD

- The Modified Therapeutic Community approach (MTC) adapts the principles and methods of the TC to the circumstances of the client with COD.
- All program activities and interactions, singly and in combination, are designed to produce change. A summary of these is provided on page 172 in your text. Please turn to page 172. *(Allow participants to access page 172.)*
- As you can see, interventions are grouped into four (4) broad categories:
  - Community enhancement (to promote affiliation with the TC community)
  - Therapeutic/educative (to promote expression and instruction)
  - Community/clinical management (to maintain personal and physical safety)
  - Vocational (to operate the facility and prepare clients for employment)
- The MTC alters the traditional TC approach in response to the client's psychiatric symptoms, cognitive impairments, reduced level of functioning, short attention span, and poor urge control. Modifications affect structure, process and interventions. These are outlined in the chart on page 174. *(Allow participants to access 174.)*
- As you look over these, you will notice that many correspond to our discussions earlier in the chapter regarding modifying group work for clients with COD.
- Before we end, I would like to point out two (2) useful textboxes I hope you will examine at your convenience:
  - On page 169, the textbox contains a well-articulated explanation of the use of confrontation in TCs and how it is modified in programs for clients who have COD. *(Allow participants to turn to page 169.)*
  - Then, on page 175, the Advice to Administrators summarizes recommendations drawn from the MTC model that are useful and applicable across all models. *(Allow participants to turn to page 175.)*

2 minutes

Wrap up

Trainer Note:

- The trainer closes the module with a brief summary statement.

- Our focus in this module has been on residential treatment settings that serve clients with COD. We examined issues related to designing, implementing, evaluating and sustaining these programs. We have also briefly looked at the Therapeutic Community and Modified Therapeutic Community.

Trainer Note:

- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 6C

Introduction

Traditional Settings and Models:
Residential Substance Abuse Treatment Programs for Clients with COD

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Chapter 6 Modules

- Module 6A
  - Essential Programming & General Considerations for Treatment of Clients with COD
- Module 6B
  - Outpatient Substance Abuse Treatment Programs for Clients with COD
- **Module 6C**
  - Residential Substance Abuse Treatment Programs for Clients with COD

7 Essential Elements & General Considerations

- Working in groups
- Involving clients in treatment and program design
- Family education

1. Screening, assessment, & referral for persons with COD
2. Physical & mental health consultation
3. Prescribing onsite psychiatrist
4. Medication & medication monitoring
5. Psychoeducational classes
6. Double trouble groups (onsite)
7. Dual recovery self-help groups (offsite)

In This Module . . .

- **Residential Substance Abuse Treatment for Clients with COD**
  - Designing
  - Implementing
  - Evaluating
  - Sustaining
  - Examples of programs

Designing Residential Programs for Clients with COD

- Intake
- Assessment
- Engagement
- Continuing Care
- Discharge Planning

TIP Exercise—Design

In groups or with partners:

1. Read recommendations on your topic.
2. Think about how these activities are conducted in your programs.
3. Describe what could stay the same and what would need to change in your program to meet the recommendations for COD programs.

(8 minutes)

Intake Steps

1. Written referral
2. Intake interview
3. Program review
4. Team meeting

Assessment Areas

- Substance abuse evaluation
- Mental health evaluation
- Health and medical evaluation
- Entitlements
- Client status

Continuing Care

Goals:

- sustaining abstinence
- continuing recovery
- community living
- vocational skills
- gainful employment
- deeper understanding
- increase responsibility
- family difficulties
- consolidating changes

Key Services:

- life skills education
- relapse prevention
- 12-Step or double trouble groups
- case management (especially for housing)
- vocational training and employment

Discharge Planning

- Housing
- Case management services
- Medication management
- Relapse prevention
- Positive peer networks
  - Mutual self help groups
- Advocacy involvement

Staffing Recommendations

- Program director
- Secretary
- Program supervisor
- 10 line staff
- ***Clinical coordinator***
- Nurse practitioner (half-time)
- Entitlements counselor (half-time)
- Vocational rehabilitation counselor (half-time)
- Consultive arrangements for medical, psychiatric, and psychological input or care

Quick TIP Exercise—Training

1. With your partner, look over the questions in Figure 6-3 (pp. 167–168).
2. Substitute the treatment model used in your workplace for each “TC” in the questions.
3. Which questions can you answer easily?
4. Which are you less sure of?

(2 minutes)

Evaluating Residential Programs for Clients with COD

1. Define operational goals in terms of the client behaviors
2. Decide on study clients and sampling
3. Locate and/or develop instruments
4. Develop plan for data collection
5. Develop plan for analysis and reporting

Sustaining Residential Programs for Clients with COD

For quality control, the CQI staff uses:

- Observation
- Key informant interviews
- Resident focus groups
- Standardized instruments
- Staff review

Therapeutic Community (TC)

Goals:

- Promote abstinence
- Decrease antisocial behavior
- Effect a global change in lifestyle, including attitudes and values

View:

- Drug abuse is a disorder of the whole person, reflecting problems in conduct, attitudes, moods, values, and emotional management
- The community is the healing agent

MODULE 7A: Special Settings and Specific Populations: Acute Care & Other Medical Settings, and Dual Recovery Mutual Self-Help Programs

Objectives

- Chapter 7 in the TIP text continues the programmatic perspective on substance abuse treatment for COD begun in Chapter 6.
  - ***Module 7A*** explores treatment in acute care and other medical settings as well as Dual Recovery Mutual Self-Help approaches.
  - *Module 7B* examines the needs of women, homeless, and criminal justice populations with COD as well as strategies that have proven effective in the treatment of these specific populations.

Trainer Note:

- The following trainer notes are for Module 7A only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides.
- Slides # 7A.1-7A.5
- Kitchen timer
- Markers and Post-It notes for participants to use on their TIP texts

Module Design

- This module blends guided examination of the text, partner and small group discussion, and large group discussion. Depending on the audience, the module can be used to:
  - Guide administrators considering development of treatment models appropriate to medical settings.
  - Allow staff currently working in medical settings to examine their program in comparison to the consensus panel's recommendations and examples.
  - Provide an opportunity for staff in treatment agencies to review the dynamics of programs in acute and primary settings.
  - Explore Dual Recovery Mutual Self Help approaches as well as advocacy organizations and resources in this area.
- The trainer will need to select those elements from material in the script that best match the purpose of the training and meet the needs of the audience. Some material may need to be adapted or deleted. For example, the questions for the large group on the text's example programs were designed for agency front line staff. These will need to be adapted or deleted if the audience is comprised mostly of administrators planning a new program in a medical setting. Conversely, the script's guided examination of pages 185-190 should be expanded for administrator audiences while other sections can be minimized.

Seating

- Discussion takes place in the module using participant dyads and small groups of 3-5 participants. Four (4) small groups will be necessary for the TIP Exercise in the latter part of the module. Should the trainer prefer participants to work with someone other than the persons they are likely to sit with initially, this re-seating should be carried out quickly before the module begins, perhaps as part of an ice-breaker or warm-up activity.

Suggested Timetable for Module 7A

Introduction ■ Reconvening ■ In This Module	3 minutes
Acute Care and Other Medical Settings ■ Background ■ Examples of Programs ■ Providing Treatment to Clients with COD in Acute Care and Other Medical Settings ■ Sustaining Programs for Clients with COD in Acute Care Settings	10 minutes
Dual Recovery Mutual Self Help Programs ■ Background—*4 minutes* ■ TIP Exercise—Dual Recovery – Set up—*1 minute* – Group Work—*10 minutes* – Report Out—*10 minutes*	25 minutes
Dual Recovery Mutual Self-Help Approaches ■ Self-Help Groups ■ Access and Linkages ■ Common Features of Dual Recovery Mutual Self-Help Fellowships ■ Empirical Evidence ■ Supported Mutual Self-Help for Dual Recovery ■ Advocating for Dual Recovery	5 minutes
Wrap up	2 minutes
TOTAL	**45 minutes**

3 minutes

OH #7A-1

OH #7A-2

Introduction

Reconvening

Trainer Note:

- Briefly review the Module 6 cluster and introduce Modules 7A and 7B.
- Check that everyone has a copy of the TIP. Lend copies or have people share.

- In our previous cluster of sessions, we examined Chapter 6 of your text. In Module 6A, we examined the essential elements in COD programming for substance abuse treatment agencies and explored some general programmatic considerations for treatment of clients with COD, including modifications to group work.
- In Modules 6B and 6C we took a closer look at outpatient settings and residential settings with particular attention to:
  - Designing
  - Implementing
  - Evaluating
  - Sustaining substance abuse treatment programs for clients with COD in these settings
- We also examined two (2) outpatient models, the Assertive Community Treatment (ACT) and the Intensive Case Management (ICM) models, and looked at a residential model, the Modified Therapeutic Community (MTC).

In This Module . . .

OH #7A-3

- Chapter 7 in your text describes substance abuse treatment for COD within special settings and with specific populations.
  - *Module 7A* will examine treatment in acute care and other medical settings. While not devoted to drug treatment, important substance abuse treatment does occur there, hence their inclusion in the TIP.
  - In addition, *Module 7A* looks at the emerging dual recovery mutual self-help programs.
  - Module 7B focuses on specific populations of clients with COD, including the homeless, women, and those in criminal justice settings. The module highlights treatment strategies that have proven effective in responding to the needs of these populations.
- Chapter 7 includes several *Advice to the Counselor* text boxes that provide you with immediate practical guidance. Several program examples are also described. Although time constraints do not allow for careful review of these during our sessions, I recommend that you review them at your convenience.

10 minutes

Acute Care and Other Medical Settings

Trainer Note:

- This section reviews background material regarding acute care and other medical settings. Program examples profiled in the text are reviewed by participant dyads followed by a trainer-guided discussion. Local medical settings most often accessed by clients with COD are also introduced in this discussion.
- The section concludes with a very quick tour of the text's examination of the essential features of providing treatment in acute care and other medical settings. These features are similar to those presented in Chapter 6 for programs in outpatient and residential settings and include:
  - Screening and assessment (in acute care and other medical settings)
  - Accessing services
  - Implementation
  - Staffing, supervision, and training
  - Team building
  - Types of training
  - Continuing care and transition issues
  - Program evaluation
- This training script was designed for front-line staff of substance abuse treatment agencies but can easily be adapted for other audiences by rewording questions, expanding examination of the text and deleting less relevant topics.

Background

- The term *acute* care refers to short-term care provided in intensive care units, brief hospital stays, and emergency rooms (ERs).
- Although these are not substance abuse treatment settings per se, the TIP includes acute care and other medical settings because important substance abuse and mental health treatment does occur in medical units.
- Given the constraints of time and resources in acute care settings or in other medical settings such as primary care offices, treatment for substance abuse and co-occurring mental disorders may be limited to detoxification, stabilization, and/or referral.
- However, brief assessments, referrals, and interventions are often possible and can be effective in moving a client to the next level of treatment.

OH #7A-4

- Several TIP documents are mentioned in your text as resources in these areas:
  - TIP 16—*Alcohol and Other Drug Screening of Hospitalized Trauma Patients* (CSAT, 1995*a*)
  - TIP 19—*Detoxification from Alcohol and Other Drugs* (CSAT, 1995*c*)
  - TIP 24—*A Guide for Substance Abuse Services for Primary Care Physicians* (CSAT, 1997*a*)
  - TIP 34—*Brief Interventions and Brief Therapies for Substance Abuse* (CSAT, 1999*a*)

Examples of Programs

- Because acute care and primary care clinics are seeing chronic physical diseases in combination with substance abuse and psychological illness (Wells et al. 1989*b*), treatment models appropriate to medical settings are emerging.
- Two (2) programs are profiled in the text boxes on pages 185 and 186: the Harborview Medical Center's Crisis Triage Unit (CTU) in Seattle and The CORE Center in Chicago. *(Allow participants to access pages 185 and 186.)*
- The first program is the Harborview Medical Center's Crisis Triage Unit (CTU) in Seattle, Washington. The Harborview Medical Center is a teaching and research hospital owned by the county and managed by the University of Washington. It has the busiest ER in the region.
- The second program is the HIV Integration Project of The CORE Center, an ambulatory infectious disease clinic in Chicago Illinois.

Participants Work in Dyads

Trainer Note:

- Ask participants to work in dyads.
- Assign programs to each dyad.
- Allow three (3) minutes for reading text boxes (or until participants appear to be finished).
- Allow one (1) minute for dyads to exchange information.

- I would like you to work with the person next to you. Each of you will take one (1) of the programs and read about it during the next three (3) minutes. Then you will tell your partner about what you read and what impressed you. Then we will talk as a group.

Trainer-led Discussion

Trainer Note:

- If necessary, probe responses to the following questions further to increase participant awareness of their connection to these acute and primary settings.
- Also, help fuel creative responses to maximize such connections for the benefit of both participants and their clients.

- ***ASK***—What acute care and primary care settings do your clients with COD access most often? Are there any in particular?
- ***ASK***—What services related to substance abuse or mental health, however limited, do your clients with COD receive there?
- ***ASK***—What are the similarities and differences between these local programs and the programs that you read about?
- ***ASK***—What relationship exists between the local settings and your agency or program? How could this relationship be improved to benefit your common clients?

Providing Treatment to Clients with COD in Acute Care and Other Medical Settings

- Beginning on page 186, your text highlights the essential features of providing treatment to clients with COD in acute care and other medical settings using the two (2) programs we read about as examples in the discussion. These features follow a similar outline to those in Chapter 6 for programs in outpatient and residential settings. *(Allow participants to access page 186.)*

Screening and assessment (in acute and other medical settings)

- Clients entering acute care or other medical facilities generally are not seeking substance abuse treatment. As the text explains, often primary care and mental health providers are not familiar with substance use disorders, which can lead to unrealistic expectations or frustrations. Thus, screening and assessment can be useful.
  - The text uses The CORE Center providing a good example of the use of effective screening and assessment procedures. To facilitate early identification of substance abuse and mental disorders within the HIV client population, The CORE Center attempts routine screening of all new clients accessing primary care.
  - At the Harborview program, clients are given a multidisciplinary evaluation that has medical, mental health, substance abuse, and social work components. Harborview does not employ any dedicated staff for performing evaluation, but rather trains a variety of staff to perform each part of the evaluation.

Accessing services

- On page 187, the text explores the importance of accessing services when the client is ready for more intensive treatment, and explores the "triage" mechanism use by The CORE Center triad.
  - The CORE Center uses a service model developed by the HIV Integration Project (HIP), which is run out of the center. The model focuses on developing a behavioral science triad that consists of a mental health counselor, a substance abuse treatment counselor, and a case manager. The triad works together to assess, engage, and facilitate clinically appropriate services for clients with HIV and COD.
  - Treatment referrals from the CORE Center are varied ranging from residential substance abuse treatment to acute psychiatric hospitalization; solid working relationships with treatment communities are needed.

  - When a client is ready for more intensive treatment, the triad provides a critical triage function to the larger substance abuse treatment and mental health services communities.

- The text also explores on page 187 the "back door" staff mechanism used by the Harborview program to ensure client access to other required services.
  - At least one "back door" staff is onsite 16 hours each day to make referrals for clients being discharged from the Harborview's Crisis Triage Unit (CTU).
  - This service has proven extremely important for ensuring both that continuing care for COD is provided to clients leaving the unit and that disposition of CTU clients is efficient.

Implementation

- Also on page 187, the text cautions administrators who may be considering integrating substance abuse treatment and/or mental health services within existing medical settings that they are introducing a new model of care and that such change may not be universally welcome.
  - Similar cautions were discussed for new COD programs in outpatient and residential settings.
  - Recommendations for dealing with this are listed on page 188.

Staffing, supervision, training, team building and evaluation

- On pages 188 and 189, the familiar issues of staffing, supervision, training, team building and evaluation are discussed.
- Once again, the need for cross-training and team building is critical. However, the text acknowledges that in acute care settings this can be more daunting than in other settings because of the greater variety of staff.
  - For example, in the Harborview program, staff members include numerous doctors, nurses, physician assistants, psychiatric residents in training, medical students, social workers, social work students, substance abuse treatment counselors, and security officers.
- Examples from the two (2) programs are also used to discuss continuing care and transition issues, and program evaluation.

Sustaining Programs for Clients with COD in Acute Care Settings

- As with programs in other settings, sustaining programs for clients with COD in acute care settings is a concern. Acute care and other medical care settings generally will rely on very different funding streams than are available to outpatient or residential substance abuse treatment programs. These funding sources will vary depending on the type of program.
  - At Harborview, for example, most funds come from the medical and mental health systems; very little substance abuse treatment money is involved. The program at Harborview has been highly visible and has a number of key county stakeholders that help avoid budget cuts.
    - Harborview also has clearly positioned itself as the program of last resort in the region and has developed its programs accordingly. Further, it has created a state-of-the-art integrated information system that enables staff to prepare detailed quality and clinical reports, which are of value to the entire system.
  - Initial funding for The CORE Center came from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the AIDS demonstration program of SAMHSA's Center for Mental Health Services (CMHS).
    - Additional funding was provided through other grants through CSAT. Funding from the Health Resources and Services Administration through the Ryan White Care Act supports opportunities to offer more intensive integrated services.
    - Other funding mechanisms, such as private foundation grants, serve as vehicles to secure financial support for these unique integrated services. At present, it is difficult to secure sustained funding from sources such as Medicare or Medicaid. Continuing funding comes from the Ryan White Care Act with some additional funds from the county.

25 minutes

Dual Recovery Mutual Self-Help Programs

Trainer Note:

- This section provides a brief introduction to Dual Recovery Mutual Self Help and then engages participants in a TIP Exercise.

4 minutes

Background

- The dual recovery mutual self-help movement is emerging from two (2) cultures: the 12-Step fellowship recovery movement and, more recently, the culture of the mental health consumer movement.
- Starting on page 190 in your text, this section of the chapter describes both cultures as well as other, consumer-driven psychoeducational efforts. The chapter mentions several resources in the literature as well as organizations that provide information, education and advocacy.
- During the past decade, mutual self-help approaches have emerged for individuals affected by COD. Mutual self-help programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change.
  - These programs are gaining recognition as more meetings are being held in both agency and community settings throughout the United States, Canada, and abroad.
- The new dual recovery mutual self-help organizations are important signs of progress in several respects:
  - First, they encourage men and women who are affected by COD to take responsibility for their personal recovery.
  - Second, they reflect a growing trend toward consumer empowerment.
  - Finally, they reflect recognition of the importance of peer support in sustained recovery.

Rationale for establishing dual recovery programs

- Several issues serve as the rationale for establishing dual recovery programs as additions to previously existing 12-Step community groups. *(Allow participants to access page 191.)*

- On page 191 your text has identified four (4):
  - Stigma and Prejudice—related to both substance abuse and mental illness
  - Inappropriate Advice (Confused Bias)—regarding the appropriate role of psychiatric medication
  - Direction for Recovery—the ability to offer direction for recovery that is based on years of collective experience and provides direction into the pathways to dual recovery
  - Acceptance—a setting of emotional acceptance, support, and empowerment (Hamilton 2001).

TIP Exercise—Dual Recovery

Set up

1 minute

Trainer Note:

- Small groups are assigned one (1) of the four (4) key issues that spurred development of dual recovery groups: 1) stigma and prejudice, 2) inappropriate advice, 3) direction for recovery, and 4) acceptance. The groups will have ten (10) minutes to apply this to their practice by answering:
  1. Is this topic ever an issue for COD clients in your agency?
  2. If any participate in 12-Step groups, what has been their experience with this issue?
  3. What could be done to address this issue in your agency? In your community?
- During the ten (10) minutes allowed for report-out, the groups will talk about which question generated the most discussion and the highlights of that discussion.
- Form at least four (4) small groups of 3-5 participants. Dyads can be used if the number of participants is small.
- Assign topics to groups. If there are more than four (4) groups, duplicate assignments.

- Working in groups, we are going to take a few minutes and talk about these issues in relation to the clients you serve, your agency and your community. Each group will focus on only one (1) of the four (4) topics.

10 minutes

OH #7A-5

Group Work

- Now that each group has an issue to focus on, I would like you to consider the following questions:

  1. Is this topic ever an issue for COD clients in your agency?
  2. If any participate in 12-Step groups, what has been their experience with this issue?
  3. What could be done to address this issue in your agency? In your community?

- You will have ten (10) minutes, and then we will report out.

Trainer Note:

- Once groups have their assignments, set timer for ten (10) minutes.
- Give one (1) minute warning.
- Call time.

---

10 minutes

Report Out

- I would like each group to tell us which question generated the most discussion. What were the highlights of your discussion?

Trainer Note:

- Allow two (2) minutes for each group to report-out.
- Thank each group for their contributions.
- Spend no more than ten (10) minutes on reports.
- Transition and continue with script below.

---

5 minutes

Dual Recovery Mutual Self-Help Approaches

Trainer Note:

- The trainer quickly reviews the text's information on the various dual recovery groups, the common features they share, how agencies can facilitate client participation, and available advocacy resources.

- The text continues with an examination of dual recovery mutual self-help approaches. 12-Step fellowship groups recognize the unique value of people in recovery sharing their personal experiences, strengths, and hope to help other people in recovery.
  - Members are free to interpret, use, or follow the 12 steps in a way that meets their own needs. The steps are used to learn how to manage addiction and mental disorders together.

Self-Help Groups

- On page 192, your text provides an overview of emerging self-help fellowships that have gained recognition in the field. *(Allow participants to access page 192.)*
- The groups are:
  1. Double Trouble in Recovery (DTR)
  2. Dual Disorders Anonymous
  3. Dual Recovery Anonymous
  4. Dual Diagnosis Anonymous
- Each of these fellowships is an independent and autonomous membership organization that is guided by the principles of its own steps and traditions. The steps and traditions are based on the original 12 Steps of Alcoholics Anonymous (AA), though as the text describes, each group has made its own modifications.
- The dual recovery fellowships are membership organizations rather than consumer service delivery programs. The fellowships function as autonomous networks, providing a system of support parallel to traditional clinical or psychosocial services.

- Page 192 includes general descriptions of how such fellowships carry out their mission, including how meetings are conducted, types of meetings, roles of members, and anonymity.

Access and Linkages

- These fellowships generally develop cooperative and informal relationships with service providers and other organizations.
  - The fellowships can be seen as providing a source of support that is parallel to formal services; that is, participation while receiving treatment and aftercare services.
- On page 193, in the left column, the text describes ways in which agencies can facilitate access to these fellowships. However, referral to dual recovery fellowships is informal. *(Allow participants to access page 193.)*
  - An agency may provide a "host setting" for one of the fellowships to hold its meetings. The agency may arrange for its clients to attend the scheduled meeting.
  - An agency may provide transportation for its clients to attend a community meeting provided by one of the fellowships.
  - An agency may offer a schedule of community meetings provided by one of the fellowships as a support to referral for clients.

Common Features of Dual Recovery Mutual Self-Help Fellowships

- Some of the features that dual recovery fellowships tend to have in common include:
  - A perspective describing co-occurring disorders and dual recovery.
  - A series of steps that provides a plan to achieve and maintain dual recovery, prevent relapse, and organize resources.
  - Literature describing the program for members and the public.
  - A format to structure and conduct meetings in a way that provides a setting of acceptance and support.

- Plans for establishing an organizational structure to guide the growth of the membership; that is, a central office, fellowship network of area intergroups, groups, and meetings.
  - An "intergroup" is an assembly of people made up of delegates from several groups in an area. It functions as a communications link upward to the central office or offices and outward to all the area groups it serves.

Empirical Evidence

- Empirical evidence described in your text suggests that participation in DTR contributes substantially to members' progress in dual recovery and should be encouraged (Magura et al., 2002; 2003).

Supported Mutual Self-Help for Dual Recovery

- On page 194, the text describes a different type of group, Support Together for Emotional/Mental Serenity and Sobriety (STEMSS), which is a psychoeducational group intervention rather than a fellowship or membership organization.
  - It has no "parent organization" and uses trained facilitators to initiate, implement, and maintain support groups for clients.

Advocating for Dual Recovery

- Advocacy organizations, such as those listed on pages 195 and 196, are at various stages of developing information materials and engaging in advocacy efforts to increase public awareness. Contact information on each organization can be found in Appendix J.

2 minutes

Wrap up

Trainer Note:

- Encourage participants to review the Advice to Counselors text boxes.
- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 7A

Introduction

Special Settings and Specific Populations:
Acute Care and Other Medical Settings, and Dual Recovery Mutual Self-Help Groups

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Chapter 6 Modules

- Module 6A
  - Essential Programming & General Considerations for Treatment of Clients with COD
- Module 6B
  - Outpatient Substance Abuse Treatment Programs for Clients with COD
- Module 6C
  - Residential Substance Abuse Treatment Programs for Clients with COD

In This Module . . .

- **Module 7A**
  - Acute care and other medical settings
  - Dual recovery and mutual self help programs

- Module 7B
  - Specific populations with COD: homeless, criminal justice, women

TIP Resources

- TIP 16—*Alcohol and Other Drug Screening of Hospitalized Trauma Patients*
- TIP 19—*Detoxification from Alcohol and Other Drugs*
- TIP 24—*A Guide for Substance Abuse Services for Primary Care Physicians*
- TIP 34—*Brief Interventions and Brief Therapies for Substance Abuse*

TIP Exercise—Dual Recovery

In groups review your assigned topic, then answer:

1. Is this topic ever an issue for COD clients in your agency?
2. If any participate in 12-Step groups, what has been their experience with this issue?
3. What could be done to address this issue in your agency? In your community?

(10 minutes)

MODULE 7B: Special Settings and Specific Populations: Specific Populations

Objectives

- Chapter 7 in the TIP text continues the programmatic perspective on substance abuse treatment for COD begun in Chapter 6.
  - *Module 7A* explores treatment in acute care and other medical settings as well as Dual Recovery Mutual Self-Help approaches.
  - ***Module 7B*** examines the needs of women, homeless, and criminal justice populations with COD as well as strategies that have proven effective in the treatment of these specific populations.

Trainer Note:

- The following trainer notes are for Module 7B only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 7B.1-7B.4
- Copies of the handout, one per participant *(See Handout section for master copy.)*
- Kitchen timer
- Markers and Post-It notes for participants to use on their TIP texts

Module Design

- This module uses primarily small and large group discussion and peer-teaching to help participants explore and then apply text information on three (3) specific populations of COD clients: homeless, criminal justice, and women. This is done using an interactive instructional method referred to as a Jigsaw. In this method participants read different information, become "experts" on a topic, and then teach that information to each other.
- Instructions for how to conduct this activity are provided in the trainer notes. A handout with questions to help guide participants as they read and prepare to share the information is also provided *(see Handout section)*. The overall purpose of the Jigsaw activity is to familiarize participants with the information available in the TIP, and to generate thoughtful discussion about how to apply the information in practice.

Familiarity with Content

- Because this module is primarily discussion, the trainer will need to be very familiar with the content. Knowing the material will make it easier to ignite interest by calling attention to overlooked information in the text should discussion fall flat, or asking follow-up questions of participants as they report-out.

Time Management

- Time management is essential in this module, particularly during the Jigsaw activity. Use of a kitchen timer can help both trainer and participants stay on schedule.

Seating

- Participants will work in groups of four (4) for most of this module. Should the trainer prefer participants to form groups with persons other than those they are likely to sit with initially, this re-seating should be carried out quickly before the module begins, perhaps as part of an ice-breaker or warm-up activity. However, no time has been allotted for this.

Suggested Timetable for Module 7B

Introduction	5 minutes
■ Reconvening	
■ In This Module	
Specific Populations	35 minutes
■ General background—*1 minute*	
■ TIP Exercise—Population Jigsaw—*25 minutes*	
– Group Formation and Assignment—*2 minutes*	
– Text Review—*10 minutes*	
– Re-grouping—*1 minute*	
– Peer Teaching—*12 minutes*	
– Report Out in Large Group—*10 minutes*	
Wrap up	5 minutes
TOTAL	**45 minutes**

5 minutes

OH #7B-1

OH #7B-2

Introduction

Reconvening

Trainer Note:

- Briefly review Module 7A and introduce Module 7B, giving some background and resource information.
- Check that everyone has a copy of the TIP. Lend copies or have people share.

- In our last session, in Module 7A, we briefly examined treatment in acute care and other medical settings.
- Given the constraints of time and resources in acute care settings or in other medical settings such as primary care offices, treatment for substance abuse and co-occurring mental disorders may be limited to detoxification, stabilization, and/or referral. However, brief assessments, referrals, and interventions are often possible and can be effective in moving a client to the next level of treatment.
- Because acute care and primary care clinics are seeing chronic physical diseases in combination with substance abuse and psychological illness (Wells et al. 1989*b*), treatment models appropriate to medical settings are emerging.
  - We reviewed the two (2) programs profiled in your text: the Harborview Medical Center's Crisis Triage Unit (CTU) in Seattle and The CORE Center in Chicago.
- We also talked about the Dual Recovery Mutual Self-help movement that is emerging from the 12-Step recovery movement and the mental health consumer movement and reviewed several types of programs.

In This Module . . .

- In recent years, awareness of COD in subpopulations such as the homeless, criminal justice clients, women with children, adolescents, and those with HIV/AIDS has been growing. This Module focuses on three (3) of these specific populations of clients with COD: the homeless, women, and those in criminal justice settings. The module also highlights treatment strategies and programs that have proven effective in responding to the needs of these populations.

OH #7B-3

- For those who would like more detailed information specific to these populations, your text recommends several relevant TIP resources on page 197. *(Allow participants to access page 197.)* They are:
  - TIP 17—*Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* (CSAT 1995*d*)
  - TIP 21—*Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* (CSAT 1995*b*)
  - TIP 30—*Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*c*)
- And upcoming TIPS on:
  - *Substance Abuse Treatment for Adults in the Criminal Justice System* (in development)[1]
  - *Substance Abuse Treatment: Addressing the Specific Needs of Women* (in development)
- These documents are downloadable along with many other resource documents at http://www.treatment.org.

[1] In development at the time of the publication of TIP 42 and now recently published.

35 minutes

Specific Populations

Trainer Note:

- This section begins with a short introduction to the three (3) populations in question as a context for the *TIP Exercise: Population Jigsaw* below. The purpose of this section and activity is to familiarize participants with the information available in their text, and to generate thoughtful discussion about how to apply this information in practice.

- The Urban Institute estimates that 2.3 to 3.5 million people are homeless annually (Burt and Aron 2000). There are many problems associated with the homeless population and among these is a disproportionate likelihood of mental illness (Rossi 1990) and use of drugs and alcohol (Fischer and Breakey 1987).
- Offenders with mental illness were likely to be using alcohol or drugs when they committed their convicting offense and likely to be incarcerated for a violent crime (Ditton 1999). The rationale for providing substance abuse treatment in prisons is based on the well-established relationship between substance abuse and criminal behavior. The overall goal of substance abuse treatment for criminal offenders, especially for those who are violent, is to reduce criminality.
- For women, the previously lower rate of addictions when compared to men appears to be vanishing. However, women with substance use disorders have more mental disorders (depression, anxiety, eating disorders, and posttraumatic stress disorder [PTSD]) and lower self-esteem as compared to their male counterparts.
  - Specialized programs for women with COD have been developed primarily to address pregnancy and childcare issues as well as certain kinds of trauma, violence, and victimization that may best be dealt with in women-only programs.
- Starting on page 197, this section of Chapter 7 provides background information on the problem of COD in these specific populations, describes some model programs and Federal initiatives, and offers recommendations for programs and services.
- In this session, we will review the material individually, then in small groups and then as part of a large group discussion. It is called a jigsaw.

25 minutes

TIP Exercise—Population Jigsaw

Trainer Note:

- Each participant will need a copy of the handout (see Handout section of module).
- Form small groups by having participants count off from 1-to-4 (1, 2, 3, 4 and repeat). Each 1-to-4 set will make up one small group.
  - All "1s" will read about the Homeless populations, pp. 197-200.
  - All "2s" will read about Criminal Justice populations, pp. 200-203.
  - All "3s" will read the first section on Women, pp. 203-207.
  - All "4s" will read the rest of the section on Women pp. 207-212.
- Participants will spend ten (10) minutes reading and preparing to teach this material to their peers in the small group by addressing the questions on their handout. The trainer will need to make sure participants stay on task.
  - Depending on the constraints of the room, participants can choose to sit alone as they read or partner with others who have their same reading assignment.
  - At the end of ten (10) minutes, small groups will reform, each containing a #1, #2, #3, and #4 member. Each member will have three (3) minutes to share his or her information. For each three (3) minute "share" session (12 minutes total), the trainer should:
    - Set timer for three (3) minutes.
    - Walk around the room to answer questions and make sure participants stay on task.
    - Call time.

2 minutes

Formation of Small Groups and Assignment

- For purposes of this activity, I would like you to count off from 1-to-4: 1, 2, 3, 4 and repeat. *(Allow participants to count off going around the room until everyone has said 1, 2, 3, or 4.)*
- All of you who are "Ones" are going to become our specialists on Homeless Populations. The information you need is on pages 197-200. Include the *Advice for the Counselor—Working with Homeless Clients with COD* text box on page 200.
- Those of you who are "Twos" will become Criminal Justice Population experts. You will do this by reading pages 200-203. Include the *Advice for the Counselor—Providing Community Supervision for Offenders with COD* on page 202.
- Those of you who are "Threes" and "Fours" will become experts on Women with COD. Because of the amount of material in the text, you will further sub-specialize.
- The "Threes" will focus on pages 203-207.
- The "Fours" will begin on page 207 with *Women, Trauma and Violence* and read through page 212.
- Both Groups 3 and 4 will need to read *Advice to the Counselor—Treatment Principles and Services for Women with COD*.

Trainer Note:

- Reading assignments are:

  #1s = pp. 197-200

  #2s = pp. 200-203

  #3s = pp. 203-207

  #4s = pp. 207-212

- Refer participants to the slide as you give them their assignment.

10 minutes

OH #7B-4

Text Review

- You will read the material for your assigned population keeping in mind the questions on your handout. You can either highlight information you think is important in your text or use the handout sheets to make notes.
- You have 10 minutes for this.
- You are free to read individually or to work with a partner or in a group with others who were assigned your population. However, you will need to be able to talk about what you read on your own as you will be teaching it to others.
- After 10 minutes, I will call time and you will regroup with the people next to you so remember who they are. That means there will be a #1, #2, #3 and #4 in your small group.
- You will each take turns teaching what you have learned to the rest of your group. Guide them through what you read using the text. The result of this exchange is that you will all become experts on all three (3) of the populations.
- Then we will talk about your findings as a large group.
- So, to repeat, first, you are to spend about 10 minutes reading about your assigned populations. Obviously, this cannot be a thorough study. However, handout sheets have been provided to help you identify key information.

Trainer Note:

- Answer any questions about the assignment and group process.
- Set timer for 10 minutes.
- Mingle and make sure participants are on task. Any talking should be related to one of the three (3) populations.
- Give a one (1)-minute warning. Call time.

1 minute

Re-grouping

- Okay. Now I would like you to reform into small groups, each with a #1, #2, #3, and a #4. *(Allow participants to regroup.)*

Peer Teaching (3 minutes x 4 peer teachings = 12 minutes total)

- You will each have three (3) minutes to guide your group through the pages you read, pointing out information in your handout or any information you highlighted in your text. We will start with #1, homeless populations.

3 minutes

Trainer Note:

- Set timer for three (3) minutes.
- Walk around the room to make sure participants stay on task.
- Call time.

- Now, let's hear from the #2 members of the group, the experts on criminal justice populations.

3 minutes

Trainer Note:

- Set timer for three (3) minutes.
- Walk around the room to make sure participants stay on task.
- Call time.

- It is time to hear from the #3 members of the group, the experts on the first section on women and COD.

3 minutes

Trainer Note: (#7)

- Set timer for three (3) minutes.
- Walk around the room to make sure participants stay on task.
- Call time.

- Finally, let's listen to the #4 members of the group, the experts on the last section on women and COD.

3 minutes

Trainer Note:

- Set timer for three (3) minutes.
- Walk around the room to make sure participants stay on task.
- Call time.

Report Out in Large Group

10 minutes

Trainer Note:

- After each question below, allow each group to respond briefly.
- Probe for thoughtful reasons. Note similarities and differences among groups.

- Now that you have had a chance to experience a jigsaw, how was this experience for you? *(Allow each group to react briefly to the Jigsaw activity.)*
- In your group, what information got the most attention? Why? *(Allow each group to respond briefly.)*
- In your group, what information do you think will be the most useful? Why? *(Allow each group to respond briefly.)*
- What do you still need to know about these specific populations? *(Suggest resources, ask other participants for suggestions, or refer to the various Appendices of the TIP.)*

5 minutes

Wrap up

Trainer Note:

- Encourage participants to review the *Advice to Counselors* text boxes.
- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

Module 7B
SPECIFIC POPULATIONS

#1s Read pages 197–200
#2s Read pages 200–203
#3s Read pages 203–207
#4s Read pages 207–212

1. What are the most important considerations or issues for this population *(according to the text)*?

2. What information about this population surprised you?

3. What surprised or intrigued you about any of the example programs discussed?

4. What elements of the *Advice to the Counselor* would be most useful to your agency's programming? To your individual practice?

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U.S. Department of Health and Human Services

Module 7B

Introduction

Special Settings and Specific Populations:
Homeless, Criminal Justice, Women

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In This Module . . .

- Module 7A
  - Acute care and other medical settings
  - Dual recovery and mutual self help programs

- **Module 7B**
  - Specific populations with COD: homeless, criminal justice, women

TIP Resources

- **TIP 17**—*Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System*
- **TIP 21**—*Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System*
- **TIP 30**—*Continuity of Offender Treatment for Substance Use Disorders From Institution to Community*

Upcoming TIPs

- *Substance Abuse Treatment for Adults in the Criminal Justice System*
- *Substance Abuse Treatment: Addressing the Specific Needs of Women*

http://www.treatment.org/

TIP Exercise—Population Jigsaw

1. Read about your assigned population and answer handout questions.

   (10 minutes)

2. Regroup so there is a 1, 2, 3, and 4 in your small group.

3. Take turns teaching each other what you've learned.

   (3 minutes each)

4. Report out on group's discussion.

MODULE 8A: A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues: Suicidality, Nicotine Dependence, and Personality Disorders

Objectives

- Chapter 8 in the TIP provides a brief overview for working with substance abuse treatment clients who also have specific mental disorders. The chapter's material has been divided into three (3) modules. Each module is intended to help participants become comfortable using the TIP as a reference for information on specific mental disorders from a COD perspective. The modules also help familiarize participants with Appendix D.
  - ***Module 8A*** addresses Suicidality, Nicotine Dependence and Personality Disorders.
  - *Module 8B* examines Mood and Anxiety Disorders, Schizophrenia and other Psychotic Disorders.
  - *Module 8C* focuses on Attention Deficit/Hyperactivity Disorder (AD/HD), Posttraumatic Stress Disorder (PTSD), Eating Disorders, and Pathological Gambling.

Trainer Note:

- The following trainer notes are for Module 8A only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 8A.1-8A.6
- Copies of the handout, one per participant *(See Handout section for master copy.)*
- Kitchen timer
- Markers and Post-It notes for participants to use on their TIP texts

Module Design

- The Module 8 cluster is designed to enable participants to explore and become comfortable with the TIP document, to appreciate the user-friendly format of Chapter 8, as well as to stimulate thought regarding application of the information to practice. Module 8A begins with a guided review of the chapter's format as a precursor to participants using the information in a small group discussion and peer-teaching activity. A handout with questions is used to help guide participants as they read and prepare to peer-teach their assigned disorder.

Familiarity with Content

- Module 8A begins with a guided exploration of the chapter's format. The trainer must be familiar with Chapter 8 in order to carry out this exploration at the brisk pace required. Because this module is primarily discussion, familiarity with the chapter will also make it easier to respond to group questions, supplement needed information, and ask follow-up questions of participants as they report-out.

Seating

- At least four (4) small groups of 3-5 participants are needed. If the number of participants is small, dyads may be used instead. Should the trainer prefer participants to form groups with someone other than the persons they are likely to sit with initially, this re-seating should be carried out quickly before the module begins, perhaps as part of an ice-breaker or warm-up activity. However, no time has been allotted for this.

Time Management

- Time management is essential in this module, particularly during the small group discussions and reports. Use of a kitchen timer can help keep both trainer and participants on schedule so that all groups will have an opportunity to participate.

Suggested Timetable for Module 8A	
Introduction ■ Reconvening	2 minutes
Chapter 8 Format Review	3 minutes
In This Module ■ Appendix D ■ Chapter Limitations	1 minute
TIP Exercise—What Counselors Should Know, Diagnostic Features and Diagnostic Criteria, Advice to the Counselor, and Case Study ■ Set up—*1 minute* ■ Small group discussion—*15 minutes* ■ Report out—*20 minutes*	36 minutes
Wrap up	3 minutes
TOTAL	**45 minutes**

2 minutes

OH #8A-1

OH #8A-2

Introduction

Reconvening

Trainer Note:

- Briefly review Modules 7A and 7B, and introduces Modules 8A, 8B and 8C.
- Check that everyone has a copy of the TIP. Lend copies or have people share.

- In our last sessions, we examined Chapter 7 in the text. In Module 7A, we briefly talked about treatment in acute care and other medical settings.
- Because acute care and primary care clinics are seeing chronic physical diseases in combination with substance abuse and psychological illness (Wells et al. 1989*b*), treatment models appropriate to medical settings are emerging.
  - We reviewed the two (2) programs profiled in your text: the Harborview Medical Center's Crisis Triage Unit (CTU) in Seattle and The CORE Center in Chicago.
- We talked about the dual recovery mutual self-help movement that is emerging from the 12-Step recovery movement and the mental health consumer movement.
- In Module 7B, we took a closer look at three (3) specific client populations with COD: the homeless, women, and those in criminal justice settings, paying particular attention to treatment strategies and programs that have proven effective in responding to the needs of these populations.

3 minutes

Chapter 8 Format Review

Trainer Note:

- This review guides participants through a portion of the chapter so they become familiar with how the information for each mental disorder is formatted. This will facilitate participant use of the information during the small group discussions. If time is a concern, the trainer will need to move briskly, *but must not delete the review*, otherwise participants will struggle and waste time during small group work.

- Chapter 8 provides a brief overview for working with substance abuse treatment clients who also have specific mental disorders. It is presented in a concise form so that the counselor can refer to this one (1) chapter to obtain basic information on each disorder.
- The chapter's goals are to:
  - Increase the familiarity of substance abuse treatment counselors with the terminology and criteria for mental disorders.
  - Make this information applicable to substance abuse treatment.
  - Provide advice on how to proceed with clients who demonstrate these disorders.

OH #8A-3

- The chapter's format is designed to facilitate access and utility. I would like to review the format before we begin the exploring the chapter's content. Please turn to page 220. *(Allow participants to access page 220.)*
- On page 220, the section begins with a general introduction to a broad category of disorders, in this case, personality disorders.
- A text box highlighting the diagnostic features and general diagnostic criteria for each mental disorder is provided. For personality disorders the text box is on the facing page (p. 221). It provides diagnostic information on personality disorders taken directly from the DSM-IV-TR.
- As discussed in earlier modules, the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM- IV-TR)* is the national standard used for the diagnosis of mental disorders and is published by the American Psychiatric Association. *(Allow participants to quickly scan the text box.)*

- Then, back on page 220, the introduction to personality disorders is followed by a brief review of selected specific personality disorders, beginning with borderline personality disorder.
  - The material is written with the client with COD in mind. Notice this first section is titled, *What counselors should know about substance abuse and borderline personality disorders.*
- This is followed on page 222 by a case study, again from the COD perspective, *Counseling a Substance Abuse Treatment Client with Borderline Personality Disorder. (Allow participants to access page 222.)*
- Also on this page is the familiar *Advice to the Counselor* text box, in this case summarizing key points to remember when *Counseling a Client with Borderline Personality Disorder.*
- On page 223, in the text box, is the diagnostic features and diagnostic criteria for borderline personality disorder taken directly from the DSM-IV-TR. *(Allow participants to briefly review the page.)*
- Then, on page 224, the cycle begins again, this time regarding antisocial personality disorder. *(Allow participants to access page 224.)*
- This pattern is used throughout the chapter to review the various mental disorders.

1 minute

OH #8A-4

In This Module . . .

- The chapter will be covered in three (3) sessions:
  - ***Module 8A*** addresses two (2) cross-cutting issues—suicidality and nicotine dependency. It also introduces personality disorders (PD) with attention given to borderline personality disorder and antisocial personality disorder.
  - *Module 8B* continues this overview and focuses on mood disorders, anxiety disorders, schizophrenia and other psychotic disorders.
  - *Module 8C* examines attention deficit/hyperactivity disorder (AD/HD), posttraumatic stress disorder (PTSD), eating disorders, and pathological gambling.

Appendix D

- Throughout this review of Chapter 8, we will also refer to Appendix D for more in-depth information on each of the disorders addressed. Please turn to page 325, or Appendix D, in your text. *(Allow participants to access page 325.)*
- Appendix D covers the same content as Chapter 8 only in greater detail. For example, if you turn to page 353, this begins the section on borderline personality disorder. *(Allow participants to access page 353.)*
- However, if you leaf through the subsequent pages, you will see that there is a wealth of information here, including:
  - Substance use among people with borderline personality disorder
  - Key issues and concerns
  - Advice on engaging these clients
  - Information about screening and assessment
  - Crisis stabilization
  - Short-term care and treatment
  - Longer term care
  - Individual counseling

Chapter Limitations

- Before we begin, it's important to point out a few common-sense limitations:
  - The material included in Chapter 8 and Appendix D is not a complete review of all disorders in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition Text Revision* (DSM-IV-TR).
  - This material is not intended to replace the comprehensive training necessary for correctly diagnosing and treating clients.
  - The *Advice to the Counselor* is a brief distillation of actions and approaches and understates the complexity involved in treating clients.
  - People with COD may have multiple combinations of the various mental disorders presented (e.g., a person with a substance use disorder, schizophrenia, and a pathological gambling problem). For purposes of clarity and brevity, the panel chose to focus the discussion on the main disorders.

Transition to TIP Exercise

- During the remainder of this module, we will be examining the material on mental disorders from a perspective relevant to your practice. In other words, from your perspective.

36 minutes

TIP Exercise—What Counselors Should Know, Diagnostic Features and Diagnostic Criteria, Advice to the Counselor, and Case Study

Trainer Note:

- The purpose of this section and activity is to familiarize participants with the information on specific mental disorders available in their TIP text, and to generate thoughtful discussion regarding application of the information in practice.
- The trainer will need to be familiar with the script in order to set up the activity with a minimum of participant questions or confusion. Only one (1) minute is set aside for this. The bulk of the time allotted is to be spent on group work and reporting out.
- At least four (4) groups of 3-5 participants are needed. Dyads can be used if the number of participants is small. If there are more than four (4) groups, assignments will be duplicated and report time shared between groups with the same assigned topic.
- Each participant will need a copy of the handout *(see Handouts section)*.
- Groups will be assigned to one (1) of the following topics and chapter pages:

  Group 1 Suicidality, pp. 214-216 – Appendix D, pp. 326-333

  Group 2 Nicotine Dependence, pp. 216-220 – Appendix D, pp. 333-347

  Group 3 Borderline Personality, pp. 220-224 – Appendix D, pp. 353-359

  Group 4 Antisocial Personality, pp. 224-226 – Appendix D, pp. 359-368

- Participants will spend *15 minutes* in small groups reading and preparing to teach this material to their peers by addressing the questions in their handout. Small groups may work on the questions together or assign them to individual members.
- The trainer will need to make sure participants stay on task and do not respond with superficial answers. When opinions are given, a reason for that stated preference must also be provided.

1 minute

Set Up

- For this exercise, we will break into four (4) small groups. You will each need a copy of the handout.
  - ***Group 1*** will focus on Suicidality, which is covered in the text on pages 214-216, and in Appendix D on pages 326-333.
  - ***Group 2*** will examine Nicotine Dependence using the information on pages 216-220. It is also covered in Appendix D on pages 333-347.
  - ***Group 3*** will look at Borderline Personality Disorder on pages 220-224. Also in Appendix D pages 353-359.
  - ***Group 4*** will study the Antisocial Personality on pages 224-226, and in Appendix D on pages 359-368.

OH #8A-5

- Each group will review the material in Chapter 8 on their assigned diagnosis and prepare to report out to the larger group by answering the questions in the handout.

OH #8A-6

- You will likely not have time to review much of Appendix D for this exercise. The pages have been included should you need further clarification of any information in Chapter 8.

Trainer Note:

- See that each participant has a copy of the handout (see Handouts section).
- Review handout with participants.

- The handout asks you to:

  1st – Briefly describe your assigned disorder in one (1) or two (2) sentences. *(Hint: Check out the Glossary in Appendix C, page 313.)*

  2nd – In the section on important things a counselor should know about this disorder and substance abuse, decide which four (4) are the most important. This is your opinion. Just tell us why you think so.

  3rd – Briefly describe the case study in your own words. Who is the client? What is the presenting problem? What happened? Summarize any discussion of the case.

  4th – Taking into consideration all that you have read, including the *Advice to the Counselor* on counseling a client with this disorder, what have you learned that you can apply to your practice?

- You may decide to answer all the questions as a group or you may decide to assign the questions to individual members of the group. However, your answer to Question 4 should reflect learning by all of the group's members.
- You will have 15 minutes for this exercise, so better get started.

15 minutes

Small Group Discussion

Trainer Note:

- Set timer for 15 minutes.
- Walk around the room to answer questions and ensure participants are on task.
- Give a one (1)-minute warning. Call time.

20 minutes

Report Out

Trainer Note:

- At the end of 15 minutes, small groups will each have five (5) minutes to share with the larger group their responses to the questions in the handout.
- Encourage groups to use their own words when reporting. If necessary, probe regarding group's reactions.
- If more than one (1) group has the same assignment, alternate the questions from the handout between the groups so that all groups participate. Be sure to keep to the time limit so that all groups have enough time to report.
- Of particular interest are the answers to Questions 2 and 4. If time is a concern, limit reports to these questions after a brief description of the disorder.
- Congratulate groups at the end of their report.
- Scripting below is drawn directly from the TIP and related to Questions 1-3 in the handout. It is provided for the trainer's convenience and reference during reports.

- Each of you will have five (5) minutes to report out. We will start with Group 1.

Cross-Cutting Issues

Suicidality

- **Suicidality**—according to the glossary, is a measure or estimate of a person's likelihood of committing suicide; a high-risk behavior associated with COD, especially (though not limited to) serious mood disorders.
- Suicidality is not a mental disorder in and of itself, but rather a high-risk behavior associated with COD, especially (though not limited to) serious mood disorders.

What counselors should know about suicide and substance abuse

- Counselors should be aware of the following facts about the association between suicide and substance abuse:
  - Abuse of alcohol or drugs is a major risk factor in suicide, both for people with COD and for the general population.
  - Alcohol abuse is associated with 25 to 50 percent of suicides. Between 5 and 27 percent of all deaths of people who abuse alcohol are caused by suicide, with the lifetime risk for suicide among people who abuse alcohol estimated to be 15 percent.
  - There is a particularly strong relationship between substance abuse and suicide among young people.
  - Comorbidity of alcoholism and depression increases suicide risk.
  - The association between alcohol use and suicide also may relate to the capacity of alcohol to remove inhibitions, leading to poor judgment, mood instability, and impulsiveness.
  - Substance intoxication is associated with increased violence, both toward others and self.

Case study: counseling a substance abuse treatment client who is suicidal

Beth M., an American-Indian woman, comes to the substance abuse treatment center complaining that drinking too much causes problems for her. She has tried to stop drinking before but always relapses. The counselor finds that she is not sleeping, has been eating poorly, and has been calling in sick to work. She spends much of the day crying and thinking of how alcohol, which has cost her her latest significant relationship, has ruined her life. She also has been taking painkillers for a recurring back problem, which has added to her problems.

The counselor tells her about a group therapy opportunity at the center that seems right for her, tells her how to register, and makes arrangements for some individual counseling to set her on the right path. The counselor tells her she has done the right thing by coming in for help and gives her encouragement about her ability to stop drinking.

Beth M. does not arrive for her next appointment, and when the counselor calls home, he learns from her roommate that Beth made an attempt on her life after leaving the substance abuse treatment center. She took an overdose of opioids (painkillers) and is recovering in the hospital. The emergency room staff found that Beth M. was under the influence of alcohol when she took the opioids.

Discussion: Although Beth M. provided information that showed she was depressed, the counselor did not explore the possibility of suicidal thinking. Counselors always should ask if the client has been thinking of suicide, whether or not the client mentions depression.

An American-Indian client, in particular, may not answer a very direct question, or may hint at something darker without mentioning it directly. Interpreting the client's response requires sensitivity on the part of the counselor. It is important to realize that such questions do not increase the likelihood of suicide. Clients who, in fact, are contemplating suicide are more likely to feel relieved that the subject has now been brought into the light and can be addressed with help from someone who cares.

It is important to note that the client reports taking alcohol and pain medications. Alcohol impairs judgment and, like pain medications, depresses brain and body functions. The combination of substances increases suicide risk or accidental overdose.

Nicotine Dependence

- **Nicotine or tobacco dependence**—In 2003 an estimated 29.8 percent of the general population aged 12 or older report current (past month) use of a tobacco product (National Survey on Drug Use and Health 2003*c*). The latest report of the Surgeon General on the Health Consequences of Smoking (U.S. Public Health Service Office of the Surgeon General 2004) provides a startling picture of the damage caused by tobacco. Tobacco smoking injures almost every organ in the body, causes many diseases, reduces health in general, and leads to reduced life span and death. Tobacco dependence also has serious consequences to nonsmokers (secondhand smoke) and the negative effects on unborn children.

- Evidence suggests that people with mental disorders and/or dependency on other drugs are more likely to have a tobacco addiction. In fact, most people with a mental illness or another addiction are tobacco dependent—about 50 to 95 percent, depending on the subgroup (Anthony and Echeagaray-Wagner 2000; Centers for Disease Control and Prevention 2001; National Institute on Drug Abuse 1999*a*; Richter 2001; Stark and Campbell 1993*b*).

- Like other addictions, tobacco dependence is a chronic disease that may require multiple treatment attempts for many individuals and there is a range of effective clinical interventions, including medications, patient/family education, and stage-based psychosocial treatments.

- Few recognize how ignoring tobacco perpetuates the stigma associated with mental illness and addiction when some ask, "Why should tobacco be addressed in mental health or addiction settings?" or "Other than increased morbidity and mortality, why should we encourage and help this group to quit?" or "What else are they going to do if they cannot smoke?"

What counselors should know about nicotine dependence

- Tobacco dependence is common in clients with other substance use disorders and mental illnesses.
- Like patients in primary care settings, clients in mental health services and addiction treatment settings should be screened for tobacco use and encouraged to quit.
- The U.S. Public Health Service Guidelines encourage the use of the "5 A's" (Ask, Advise, Assess, Assist, Arrange Follow-Up) as an easy road map to guide clinicians to help their patients who smoke:
  - **A**sk about tobacco use and document in chart
  - **A**dvise to quit in a clear, strong, and personal message
  - **A**ssess willingness to make a quit attempt and consider motivational interventions for the lower motivated and assist those ready to quit
  - **A**ssist in a quit attempt by providing practical counseling, setting a quit date, helping them to anticipate the challenges they will face, recommending the use of tobacco dependence treatment medications, and discussing options for psychosocial treatment, including individual, group, telephone, and Internet counseling options
  - **A**rrange follow-up to enhance motivation, support success, manage relapses, and assess medication use and the need for more intensive treatment if necessary
- Assessment of tobacco use includes assessing the amount and type of tobacco products used (cigarettes, cigars, chew, snuff, etc.), current motivation to quit, prior quit attempts (what treatment, how long abstinent, and why relapsed), withdrawal symptoms, common triggers, social supports and barriers, and preference for treatment.
- Behavioral health professionals already have many of the skills necessary to provide tobacco dependence psychosocial interventions.
- Smokers with mental illness and/or another addiction can quit with basic tobacco dependence treatment, but may also require motivational interventions and treatment approaches that integrate medications and psychosocial treatments.

- Tobacco treatment is cost-effective, feasible, and draws on principles of addictions and co-occurring disorders treatment.
- The current U.S. Clinical Practice Guidelines indicate that all patients trying to quit smoking should use first-line pharmacotherapy, except in cases where there may be contraindications.
- Currently there are six (6) FDA-approved treatments for tobacco dependence treatment: bupropion SR and five (5) Nicotine Replacement Treatments (NRTs): nicotine polacrilex (gum), nicotine transdermal patch, nicotine inhaler, nicotine nasal spray, and nicotine lozenge.
- Tobacco treatment medications are effective even in the absence of psychosocial treatments, but adding psychosocial treatments to medications enhances outcomes by at least 50 percent.
- Specific coping skills should be addressed to help smokers with mental or substance use disorders to cope with cravings associated with smoking cues in treatment settings where smoking is likely to be ubiquitous.
- When clients with serious mental illnesses attempt to quit smoking, watch for changes in mental status, medication side effects, and the need to lower some psychiatric medication dosages due to tobacco smoke interaction.

Program-level changes

- As with other COD, the most effective strategies to address tobacco include both enhancing clinician skills and making program and system changes. Effective steps for addressing tobacco at the treatment program level are listed in an outline in the text box below.

Steps for Addressing Tobacco Within Treatment Programs	
1	Acknowledge the challenge.
2	Establish a leadership group and commit to change.
3	Create a change plan and implementation timeline.
4	Start with easy system changes.
5	Assess and document in charts nicotine use, dependence, and prior treatments.
6	Incorporate tobacco issues into client education curriculum.
7	Provide medications for nicotine dependence treatment and required abstinence.
8	Conduct staff training.
9	Provide treatment and recovery assistance for interested nicotine-dependent staff.
10	Integrate motivation-based treatments throughout the system.
11	Develop addressing tobacco policies.
12	Establish ongoing communication with 12-Step recovery groups, professional colleagues, and referral sources about system changes.

Source: Ziedonis and Williams 2003*a*.

Case study: addressing tobacco in an individual with panic disorder and alcohol dependence

Tammy T. is a 47-year-old widow who has been treated in a substance abuse outpatient program for co-occurring alcohol dependence and panic disorder. She is about 9 months abstinent from alcohol and states that she is now ready to address her tobacco addiction. When she first entered treatment she was not ready to quit tobacco. Her substance abuse counselor recognized her ambivalence and implemented some motivational interventions and followup on this topic over the course of the 9 months of her initial recovery. This persistence was perceived as expressing empathy and concern, and Tammy T. eventually recognized the need to quit smoking as part of a long-term recovery plan. She was now ready to set a quit date.

Tammy T. started smoking at age 17. Her only period of abstinence was during her pregnancy. She quickly resumed smoking after giving birth. She cut back from 30 cigarettes per day (1.5 packs) to 20 cigarettes per day (1 pack) in the last year but has been unable to quit completely. She lives with her brother, who also smokes. Her panic disorder is well controlled by sertraline (Zoloft), and she sees a counselor monthly and a psychiatrist four times a year for medication management. She works full time in a medical office as an office manager and must leave the building to smoke during work hours. Tammy T. drank alcohol heavily for many years, consuming up to 10 beers 3 to 5 times per week until about 1 year ago. At the advice of her physician, who initiated treatment for panic attacks, she was able to quit using alcohol completely. She was encouraged by her success in stopping drinking, but has been discouraged about continuing to smoke.

In creating a quit plan for Tammy T., it was important for the counselor to determine what supports she has available to help her to quit. Encouraging her brother to quit at the same time was seen as a useful strategy, as it would help to remove smoking from the home environment. Tammy T. was willing to attend a 10-week group treatment intervention to get additional support, education, and assistance with quitting. Some clients may desire individual treatment that is integrated into their ongoing mental health or addiction treatment, or the use of a telephone counseling service might be explored since it is convenient and is becoming more widely available. In discussing medication options, Tammy T. indicated that she was willing to use the nicotine inhaler. Medication education enhanced compliance with the product and increased its effectiveness. She was encouraged to set a quit date and to use nicotine replacement starting at the quit date and in an adequate dose.

Tammy T. was taking sertraline for her panic disorder (a selective serotonin reuptake inhibitor [SSRI]) and therefore another medication option might be to add bupropion SR (not an SSRI) to her current medications for a period of 12 weeks, specifically to address smoking if another quit attempt is needed in the future. If she had not been successful in this attempt, it would have been important to motivate her for future quit attempts and consider increasing the dose and/or duration of the medication or psychosocial treatment. In this case the group treatment, 6 months of NRT inhaler, and eliciting her bother's agreement to refrain from smoking in the house resulted in a successful quit attempt, as well as continued success in her recovery from co-occurring panic disorder and alcohol dependence.

Personality Disorders

- **Personality disorder (PD)**—the essential diagnostic feature is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two (2) of the following areas: cognition, affectivity, interpersonal functioning, or impulse control. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood. The pattern is not better accounted for as a manifestation or consequence of another mental disorder and is not due to the direct physiological effects of a substance or a general medical condition.

- Those who have PDs tend to have difficulty forming a genuinely positive therapeutic alliance. They tend to frame reality in terms of their own needs and perceptions and not to understand the perspectives of others. Also, most clients with PDs tend to be limited in terms of their ability to receive, accept, or benefit from corrective feedback.

- A further difficulty is the strong countertransference clinicians can have in working with these clients, who are adept at "pulling others' chains" in a variety of ways. Specific concerns will, however, vary according to the specific PD and other individual circumstances.

Borderline Personality Disorder

- **Borderline personality disorder (BPD)**—the essential diagnostic feature is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, along with marked impulsivity that begins by early adulthood and is present in a variety of contexts. Individuals with BPD make frantic efforts to avoid real or imagined abandonment. They have a pattern of unstable and intense relationships and there may be an identity disturbance characterized by markedly and persistently unstable self-image or sense of self. Individuals with

this disorder display impulsivity in at least two (2) areas that are potentially self-damaging. They display recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior. They may display affective instability that is due to a marked reactivity of mood. They may be troubled with chronic feelings of emptiness and frequently express inappropriate, intense anger or have difficulty controlling their anger. During periods of extreme stress, transient paranoid ideation or dissociative symptoms may occur, but these are generally of insufficient severity or duration to warrant an additional diagnosis.

What counselors should know about substance abuse and borderline personality disorders

- People with BPD may use drugs in a variety of ways and settings.
- At the beginning of a crisis episode, a client with this disorder might take a drink or a different drug in an attempt to quell the growing sense of tension or loss of control.
- People with BPD may well use the same drugs of choice, route of administration, and frequency as the individuals with whom they are interacting.
- People with BPD often use substances in idiosyncratic and unpredictable patterns.
- Polydrug use is common, which may involve alcohol and other sedative-hypnotics taken for self-medication.
- Individuals with BPD often are skilled in seeking multiple sources of medication that they favor, such as benzodiazepines. Once they are prescribed this medication in a mental health system, they may demand to be continued on the medication to avoid dangerous withdrawal.

Case Study: counseling a substance abuse treatment client with borderline personality disorder

Ming L., an Asian female, was 32 years old when she was taken by ambulance to the local hospital's emergency room. Ming L. had taken 80 Tylenol capsules and an unknown amount of Ativan in a suicide attempt. Once medically stable, Ming L. was evaluated by the hospital's social worker to determine her clinical needs.

The social worker asked Ming L. about her family of origin. Ming L. gave a cold stare and said, "I don't talk about that." Asked if she had ever been sexually abused, Ming L. replied, "I don't remember." Ming L. acknowledged previous suicide attempts as well as a history of cutting her arm with a razor blade during stressful episodes. She reported that the cutting "helps the pain."

Ming L. denied having "a problem" with substances but admitted taking "medication" and "drinking socially." A review of Ming L.'s medications revealed the use of Ativan "when I need it." It soon became clear that Ming L. was using a variety of benzodiazepines (anti-anxiety medications) prescribed by several doctors and probably was taking a daily dose indicative of serious dependence. She reported using alcohol "on weekends with friends" but was vague about the amount. Ming L. did acknowledge that before her suicide attempts, she drank alone in her apartment. This last suicide attempt was a response to a breakup with her boyfriend. Ming L.'s insurance company is pushing for immediate discharge and has referred her to the substance abuse treatment counselor to "address the addictions problem."

The counselor reads through notes from an evaluating psychiatrist and reviews the social worker's report of his interview with Ming. She notes that the psychiatrist describes the client as having a severe borderline personality disorder, major recurrent depression, and dependence on both benzodiazepines and alcohol. The counselor advises the insurance company that unless the client's co-occurring disorders also are addressed, there is little that substance abuse treatment counseling will be able to accomplish.

Discussion: While it is important not to refuse treatment for clients with co-occurring disorders, it is also important to know the limits of what a substance abuse treatment counselor or agency can and cannot do realistically. A client with problems this serious is unlikely to do well in standard substance abuse treatment unless she also is enrolled in a program qualified to provide treatment to clients with borderline personalities, and preferably in a program that offers treatment designed specially for this disorder such as Dialectical Behavior Therapy (Linehan et al. 1999) (although substance abuse treatment programs are increasingly developing their capacities to address specialized mental disorders). She is likely to need complicated detoxification either on an inpatient basis or in a long-term outpatient program that knows how to enclose the kinds of behavioral chaos that borderline clients often experience.

Antisocial Personality Disorder

- **Antisocial personality disorder (APD)**—according to the glossary, is an illness whose two (2) essential features are: (1) a pervasive disregard for and violation of the rights of others, and (2) an inability to form meaningful interpersonal relationships. Deceit and manipulation are important manifestations of antisocial personality disorder.

What counselors should know about substance abuse and antisocial personality disorder

- The prevalence APD and substance abuse is high.
- Much of substance abuse treatment is particularly targeted to those with APD and substance abuse treatment alone has been particularly effective for these disorders.
- The majority of people with substance use disorders are not sociopathic except as a result of their addiction.
- Most people diagnosed as having APD are not true psychopaths—that is, predators who use manipulation, intimidation, and violence to control others and to satisfy their own needs.
- Many people with APD use substances in a polydrug pattern involving alcohol, marijuana, heroin, cocaine, and methamphetamine.
- People with APD may be excited by the illegal drug culture and may have considerable pride in their ability to thrive in the face of the dangers of that culture. They often are in trouble with the law. Those who are more effective may limit themselves to exploitative or manipulative behaviors that do not make them as vulnerable to criminal sanctions.

Case study: counseling a substance abuse treatment client with antisocial personality disorder

Mark R., a Hispanic/Latino male, was 27 years old when he was arrested for driving while intoxicated. Mark R. presented himself to the court counselor for evaluation of the possible need for substance abuse treatment. Mark R. was on time for the appointment and was slightly irritated at having to wait 20 minutes due to the counselor's schedule. Mark R. was wearing a suit (which had seen better days) and was trying to present himself in a positive light.

Mark R. denied any "problems with alcohol" and reported having "smoked some pot as a kid." He denied any history of suicidal thinking or behavior except for a short period following his arrest. He acknowledged that he did have a "bit of a temper" and that he took pride in the ability to "kick ass and take names" when the situation required. Mark R. denied any childhood trauma and described his mother as a "saint." He described his father as "a real jerk" and refused to give any other information.

In describing the situation that preceded his arrest, Mark R. tended to see himself as the victim, using statements such as "The bartender should not have let me drink so much," "I wasn't driving that bad," and "The cop had it in for me." Mark R. tended to minimize his own responsibility throughout the interview. Mark R. had been married once but only briefly. His only comment about the marriage was, "She talked me into it but I got even with her." Mark R. has no children and lives alone in a studio apartment. Mark R. has attended two meetings of Alcoholics Anonymous (AA) "a couple of years ago before I learned how to control my drinking."

The counselor coordinates closely with the parole officer and arranges several three-way meetings. He carefully reviews details of the court contract and conditions of parole and keeps court records up to date. His work with Mark R. centers on clarifying expectations.

Discussion: It is likely that Mark R. has antisocial personality disorder. Clients with this disorder usually are very hard to engage in individual treatment and are best managed through strict limits with clear consequences. With such an individual, it is important to maximize the interaction with the court, parole officers, or other legal limit setters. This enforces the limits of treatment, and prevents the client from criticizing and blaming one agency representative to the other.

People with this disorder are best managed in group treatment that addresses both their substance abuse and antisocial personality disorder. In such groups the approach is to hold the clients responsible for their behavior and its consequences and to confront dishonest and antisocial behavior directly and firmly and stress immediate learning experiences that teach corrective responses.

It is important to differentiate true antisocial personality from substance-related antisocial behavior. This can best be done by looking at how the person relates to others throughout the course of his or her life. Persons with this disorder will have evidence of antisocial behavior preceding substance use and even during periods of enforced abstinence. It also is important to recognize that people with substance-related antisocial behavior may be more likely to have major depression than other typical personality disorders. However, the type and character of depressions that may be experienced by those with true APD have been less well characterized, and their treatment is unclear.

3 minutes

Wrap up

Trainer Note:

- Thank all groups for their work and shared insights.
- Encourage participants to review the *Advice to Counselors* text boxes.
- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

Module 8A
TIP Exercise-WHAT COUNSELORS SHOULD KNOW . . .

Group 1	**Suicidality** pp. 214-216 – Appendix D, pp. 326-333	**Group 3**	**Borderline Personality** pp. 220-224 – Appendix D, pp. 353-359
Group 2	**Nicotine Dependence** pp.216-220 – Appendix D, pp. 333-347	**Group 4**	**Antisocial Personality** pp. 224-226 – Appendix D, pp. 359-368

1. Briefly describe your assigned disorder in one (1) or two (2) sentences.
   (Hint: Check out the Glossary in Appendix C, page 313.)

2. In your opinion, what are the four (4) most important things a counselor should know about this disorder and substance abuse? Why?

3. Briefly describe the case study. *(Use back of sheet for notes.)*
   - Who is the client?
   - What is the presenting problem?
   - What happened?
   - Summarize any discussion of the case.

4. Taking into consideration all you have read, including the A*dvice to the Counselor* on counseling a client with this disorder, what have you learned that you can apply to your practice?

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 8A

Introduction

A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues: *Suicidality, Nicotine Dependence, and Personality Disorders*

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Module 7

- Module 7A
  - Acute care and other medical settings
  - Dual recovery and mutual self help programs

- Module 7B
  - Specific populations with COD: homeless, criminal justice, women

Chapter's Format

- Disorder category (i.e. Personality, Mood, Anxiety, Psychotic)
  - What counselors should know about this category and substance abuse
- Specific disorders within each category
  - What counselors should know about substance abuse and the specific disorder
  - Diagnostic features and criteria from the DSM-IV-TR
  - Case study
  - Advice to the counselor

In This Module . . .

Module 8A

- Cross-Cutting Issues: Suicidality, Nicotine Dependence
- Personality Disorders

Module 8B

- Mood and Anxiety Disorders
- Schizophrenia and Other Psychotic Disorders

Module 8C

- Attention Deficit/Hyperactivity Disorder (AD/HD)
- Posttraumatic Stress Disorder (PTSD)
- Eating Disorders
- Pathological Gambling

Appendix D

TIP Exercise—
Group Assignments

Group 1—Suicidality (pp. 214–216)
- Appendix D, pp. 326–333

Group 2—Nicotine Dependence (pp. 216–220)
- Appendix D, pp. 333–347

Group 3—Borderline Personality (pp. 220–224)
- Appendix D, pp. 353–359

Group 4—Antisocial Personality (pp. 224–226)
- Appendix D, pp. 359–368

(15 minutes)

TIP Exercise—

What Counselors Should Know, Diagnostic Features & Criteria, Advice to the Counselor, & Case Study

With your group:

- Read the text section on your assigned diagnosis.
- Answer the handout questions.
- Prepare to teach the larger group.

(15 minutes)

MODULE 8B: A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues: Mood Disorders, Anxiety Disorders, Schizophrenia and Other Psychotic Disorders

Objectives

- Chapter 8 in the TIP provides a brief overview for working with substance abuse treatment clients who also have specific mental disorders. The chapter's material has been divided into three (3) modules. Each module is intended to help participants become comfortable using the TIP as a reference for information on specific mental disorders from a COD perspective. The modules also help familiarize participants with Appendix D.
  - *Module 8A* addresses Suicidality, Nicotine Dependence and Personality Disorders.
  - ***Module 8B*** examines Mood and Anxiety Disorders, Schizophrenia and other Psychotic Disorders.
  - *Module 8C* focuses on Attention Deficit/Hyperactivity Disorder (AD/HD), Posttraumatic Stress Disorder (PTSD), Eating Disorders, and Pathological Gambling.

Trainer Note:

- The following trainer notes are for Module 8B only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 8B.1-8B.5
- Copies of the TIP ZIP Test, one per participant, if that option is chosen *(See Handout section for master copy.)*
- Copies of the Role Play or Case Study Handout, one per participant *(See Handout section for master copy.)*
- Kitchen timer
- Markers and Post-It notes for participants to use on their TIP texts

Module Design

- The Module 8 cluster is designed to enable participants to explore and become comfortable with the TIP document, to appreciate the user-friendly format of Chapter 8, as well as to stimulate thought regarding application of the information to practice. Module 8B includes an optional TIP ZIP test. The major part of the session is dedicated to an activity where participants review assigned text information, use this to create a role-play in small groups and then perform the role-play as a means of peer teaching. A handout guides participants through the activity. If the environment is not conducive to a role-play activity, small groups can create a case study instead, illustrating key points from the assigned material. A participant handout is also provided for the case study option.

Familiarity with Content

- Because of time constraints, the trainer will need to be thoroughly familiar with the module and have selected beforehand which option is most appropriate for the module's central activity.

Seating

- At least three (3) small groups of 3-6 participants are needed. If the number of participants is small, dyads may be used instead. Should the trainer prefer participants to form groups with someone other than the persons they are likely to sit with initially, this re-seating should be carried out quickly before the module begins, perhaps as part of an ice-breaker or warm-up activity. However, time has not been allotted for this.

Time Management

- The bulk of the time allotted is to be spent on group work and reporting out. Use of a kitchen timer can help keep both trainer and participants on schedule so that all groups will have an opportunity to participate.

Suggested Timetable for Module 8B	
Introduction ■ Chapter's Format ■ In This Module	3 minutes
TIP ZIP Test *Optional*	5 minutes
TIP Exercise—Mood and Anxiety Disorders, Schizophrenia and Other Psychotic Disorders ■ Set up—*2 minutes* ■ Small Group Discussion—*20 minutes* ■ Report Out—*12 minutes*	34 minutes
Wrap up ■ Review of TIP ZIP Test	3 minutes
TOTAL	**45 minutes**

3 minutes

OH #8B-1

Introduction

Reconvening

Trainer Note:

- Briefly review the Module 8A-8C cluster and introduces Module 8B.
- Check that everyone has a copy of the TIP. Lend copies or have people share.

- In our last session, we began or review of Chapter 8. The chapter's goals are to:
  - Increase the familiarity of substance abuse treatment counselors with the terminology and criteria for mental disorders.
  - Make this information applicable to substance abuse treatment.
  - Provide advice on how to proceed with clients who demonstrate these disorders.

Chapter's Format

OH #8B-2

- We also took some time to examine the overall format of Chapter 8. This chapter provides a brief overview for working with substance abuse treatment clients who also have specific mental disorders. It is presented in a concise format so that the counselor can refer to this one (1) chapter to obtain basic information.
- First, there is a description of the broad category of disorder, such as personality disorders or mood disorders. Then discussion focuses on selected disorders that fit under the broad category, such as borderline personality disorder, or antisocial personality disorder.
- A great deal of care has been taken so that discussions, case studies, and advice are all presented with substance use in mind as a co-occurring disorder.
- The chapter also contains the diagnostic features and diagnostic criteria from the DSM-IV-TR for each disorder addressed.
- Also, remember that Appendix D is a companion to this chapter. It uses a similar format but addresses the disorders in much greater detail, including discussions on assessment and engagement.

OH #8B-3

In This Module . . .

- The chapter is covered in three (3) sessions:
  - Module 8A addressed two (2) cross-cutting issues-suicidality and nicotine dependency, and it introduced personality disorders (PD) with attention to the borderline personality disorder and antisocial personality disorder.
  - ***Module 8B*** continues this overview and focuses on mood disorders, anxiety disorders, schizophrenia and other psychotic disorders.
  - Module 8C will examine attention deficit/hyperactivity disorder (AD/HD), posttraumatic stress disorder (PTSD), eating disorders, and pathological gambling.

Transition to Optional TIP ZIP Test

- Before we get started with the material for today's session, let's take a TIP ZIP Test.

5 minutes

TIP ZIP Test *Optional*

Trainer Note:

- A brief initial activity, the TIP ZIP Test focuses participant attention on the module's topics. If time is a concern, this activity may be skipped.
- Each participant will need a copy of the TIP ZIP test. A master form is included in the handout section.
- Five (5) minutes is allowed for the test. Use a kitchen timer and enforce the time.
- Participants may NOT use the TIP text during test taking. Participants may discuss their responses with their neighbor during the last two (2) minutes and change their responses if they wish.
- Once the test is completed, participants can auto-correct as responses become evident during the session. Small prizes such as candy or markers can be given out at the end of the session to those with the most correct answers.

- The test's questions deal with some of the topics we will cover today. There are no grades, no penalties. You will have five (5) minutes to complete it. Please close your TIP texts and do not peek. During the last two (2) minutes, you can check your answers with your neighbor's and change your responses if you wish. But you can't read the TIP until we resume the module. At the end of the session, we will take a final tally of our responses.

Trainer Note:

- Have participants close their TIPs and put them out of reach.
- Hand out TIP ZIP Test for Module 8B.
- Allow three (3) minutes for testing.
- Allow two (2) minutes for discussion of their responses with their neighbors. Participants may change their answers if they wish.
- Call time and then continue module training.

Transition to TIP Activity

- As in Module 8A, during the remainder of this module we will examine the TIP material on mental disorders from your perspective.

34 minutes

TIP Exercise—Mood and Anxiety Disorders, Schizophrenia and Other Psychotic Disorders

Trainer Note:

- The purpose of this section and central activity is to familiarize participants with the information on specific mental disorders available in their TIP text, and to generate discussion regarding application of the information in a creative and relaxed manner.
- The trainer will need to be familiar with the activity's process and options in order to clearly and quickly set-up the activity. Only two (2) minutes are set aside for this. The bulk of the time is to be spent on group work and reporting out.
- Depending on the size of the group, the trainer will select one (1) learning activity for this TIP Exercise: creating a role-play or developing a case study.
  - ***Role Play Option***—Participant directions for this activity are available in the handout section.
  - ***Case Study Option***—If the group is very large, or the environment is not conducive to a role-play, the trainer may elect to have participant groups create a case study instead as a way to illustrate the assigned diagnosis and related material. The trainer can then have as many groups as time permits read their cases during the report out. Participant directions for this activity are available in the handout section.
- ***Options for more than 18-20 participants***—If the number of participants results in more than three (3) groups, assignments can be duplicated or the case study option can be selected (see above). Only 12 minutes have been set aside for reporting out activities where three (3) groups spend four (4) minutes performing their role-plays. In cases of duplicate groups, selection of groups to perform can be done at report time by having someone from each group pick a slip of paper from a hat, only three (3) of which will be marked "Perform."
- ***Group work***—Participants will spend 20 minutes in small groups reading and preparing to teach their peers the assigned diagnosis material by creating a role-play script (or a case study, see above).

2 minutes

Set Up

- During the remainder of this module, we will be examining the material on the selected mental disorders in groups of 3-6 participants.
- The purpose of this activity is to help you become familiar with the information in the TIP and discuss it in a creative and hopefully interesting manner.

Trainer Note:

- Distribute handout for Role Play Activity (or Case Study).
- Divide participants into at least three (3) groups of 3-6 participants. Dyads can be used if the number of participants is small.
- ***Group assignments***—Assign groups to one (1) of the following topics and chapter pages:
  - Group 1: Mood Disorder, pp. 226-230; and Appendix D, pp. 369-383.
  - Group 2: Anxiety Disorder, pp. 226-230; and Appendix D, pp. 369-383.
  - Group 3: Schizophrenia, pp. 231-235; and Appendix D, pp. 385-400.
    - Call attention to the fact that although the TIP text combines discussion of mood disorder and anxiety disorder, the diagnoses are different.

OH #8B-4

- Each group will be responsible for one (1) of the disorders we are discussing today:
  - **Group 1** will focus on Mood Disorder
  - **Group 2** will examine Anxiety Disorder
  - **Group 3** will cover Schizophrenia

- *Notice:* On page 226, the TIP combines discussion of mood disorder and anxiety disorder. *(Allow participants to access page 226.)*
- However, the diagnostic features are described in separate text boxes. Mood disorders are described on pages 227 and 228. Anxiety disorders are on page 230.
- Diagnosis and discussion for schizophrenia are separate.
- You will likely not have time to review much of Appendix D for this exercise. The pages have been included should you need further clarification of any information in Chapter 8.

20 minutes

OH #8B-5

Small Group Discussion

Trainer Note:

- Describe the group work for the Role Play Activity (or Case Study). Participants will spend 20 minutes in small groups reading and preparing to teach their peers the assigned diagnosis material by creating a role-play script (or a case study, see above).

- For this activity, you will spend 20 minutes creating a role-play based on the information on your assigned mental disorder. You will also be getting ready to perform it.
- You are not writing a full-length screenplay. Just a brief scene that will take 3-5 minutes to perform and that will teach the rest of us some of the key points about this disorder.
- A few things to keep in mind:
  - This should be a brief scene that would happen in your agency or program (i.e., during an intake interview, group session, counseling session, etc.).
  - The “client” in question should be a person with COD, therefore suffering from both the mental disorder in question and a substance use disorder.
  - Every member of your group must have a role in this activity (i.e., performers, scriptwriters, director, prop manager, etc.).

- Are there any questions?

Trainer Note:

- Set timer for 20 minutes.
- The trainer should walk around the room to answer questions and make sure all group members participate and stay on task.
- Give a five (5)-minute warning.
- Give a one (1)-minute warning. Call time.

12 minutes

Report Out

Trainer Note:

- At the end of 20 minutes, three (3) of the small groups will each have four (4) minutes to perform their role-play. (Or share their case study if that option is selected).

- Remember that each of you will have no more than 3-4 minutes for your role-play (or case study). If necessary, I will call time so every group has a chance to report. We will start with Group 1, then Group 2 and Group 3.

Trainer Note:

- Set timer for four (4) minutes. Call time.
- Congratulate group and then call on the next group until all groups have performed.

- Now, to end our session, I would like each group to share briefly what they have learned from today's session that they can apply to their practice.

Trainer Note:

- Quickly go around and have groups share what they have learned that they will apply to their practice.

3 minutes

Wrap up

Trainer Note:

- Thank all groups for their work and sharing their insights.
- Review answers to TIP ZIP Test (if this option is used).
- Encourage participants to review the *Advice to Counselors* text boxes.
- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

Module 8B
TIP ZIP TEST

1. The essential feature of a major depressive episode is a period of at least _____ during which there is either depressed mood or the loss of interest or pleasure in nearly all activities.
   a. 2 weeks
   b. 2 months
   c. 2 years *(p. 227)*

2. T or F—About one-half of individuals with a substance use disorder has an affective or anxiety disorder at some time in their lives. *(p. 226)*

3. _____ may be the group at highest risk for combined mood disorder and substance use problems.
   a. Women
   b. Adolescents
   c. The elderly *(p. 375)*

4. T or F—Both schizophrenia and bipolar disorder are relatively rare compared to major depressive illness, which has lifetime incidences in the general population of 10 to 25 percent for women and 5 to 12 percent for men. *(p. 389)*

5. T or F—During the first months of sobriety, many people with substance use disorders may exhibit symptoms of depression that fade over time and that are related to acute withdrawal. *(p. 226)*

6. T or F—When working with a client with a psychotic disorder, special care should be taken with regard to client education and group discussion about higher power issues. *(p. 397)*

7. T or F—Withdrawal from depressants, opioids, and stimulants invariably includes potent anxiety symptoms. *(p. 226)*

8. T or F—The following are diagnostic criteria for schizophrenia:
   - Restlessness or feeling keyed up or on edge
   - Being easily fatigued
   - Difficulty concentrating or mind going blank
   - Irritability
   - Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep) *(p. 230)*

Module 8B
TIP ZIP TEST—*KEY*

1. The essential feature of a major depressive episode is a period of at least _____ during which there is either depressed mood or the loss of interest or pleasure in nearly all activities.
   a. ***2 weeks***
   b. 2 months
   c. 2 years *(p. 227)*

2. ***T*** or F—About one-half of individuals with a substance use disorder has an affective or anxiety disorder at some time in their lives. *(p. 226)*

3. _____ may be the group at highest risk for combined mood disorder and substance use problems.
   a. Women
   b. Adolescents
   c. ***The elderly*** *(p. 375)*

4. ***T*** or F—Both schizophrenia and bipolar disorder are relatively rare compared to major depressive illness, which has lifetime incidences in the general population of 10 to 25 percent for women and 5 to 12 percent for men. *(p. 389)*

5. ***T*** or F—During the first months of sobriety, many people with substance use disorders may exhibit symptoms of depression that fade over time and that are related to acute withdrawal. *(p. 226)*

6. ***T*** or F—When working with a client with a psychotic disorder, special care should be taken with regard to client education and group discussion about higher power issues. *(p. 397)*

7. ***T*** or F—Withdrawal from depressants, opioids, and stimulants invariably includes potent anxiety symptoms. *(p. 226)*

8. T or ***F***—The following are diagnostic criteria for schizophrenia:
   - Restlessness or feeling keyed up or on edge
   - Being easily fatigued
   - Difficulty concentrating or mind going blank
   - Irritability
   - Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep) *(p. 230)*

These are diagnostic criteria for Anxiety Disorder

Module 8B
ROLE-PLAY OPTION

Group 1	**Mood Disorder**, pp. 226-230 – Appendix D, pp. 369-383
Group 2	**Anxiety Disorder**, pp. 226-230 – Appendix D, pp. 369-383
Group 3	**Schizophrenia**, pp. 231-235 – Appendix D, pp. 385-400

1. Review information about your assigned diagnosis.

2. With your group, create a 3-5 minute role-play that illustrates key information about the disorder (drawn from your reading of *What Counselors Should Know, Diagnostic Features & Criteria, Advice to the Counselor, Case Study* and Appendix D).

    - This should be a brief scene that would happen in your agency or program (i.e., during an intake interview, group session, counseling session, lunch, etc.).
    - The "client" in question should be a person with COD; therefore, both the mental and a substance use disorder must be present.
    - Every group member must have a role in this activity (i.e., performers, scriptwriters, director, prop manager, etc.).

3. Be prepared to teach the larger group by performing your role-play.

4. Be prepared to answer, "What did you learn that you can apply to your practice?"

Module 8B
CASE STUDY OPTION

Group 1	**Mood Disorder**, pp. 226-230 – Appendix D, pp. 369-383
Group 2	**Anxiety Disorder**, pp. 226-230 – Appendix D, pp. 369-383
Group 3	**Schizophrenia**, pp. 231-235 – Appendix D, pp. 385-400

1. Read about your assigned diagnosis.

2. With your group, create a case study similar to those in the text that illustrates some of the key information for your assigned disorder (drawn from your reading of *What Counselors Should Know, Diagnostic Features & Criteria, Advice to the Counselor, Case Study* and Appendix D).

    - This should involve a client that would be likely to be seen in your agency or program (i.e., during an intake interview, group session, counseling session, lunch, etc.).
    - The "client" in question should be a person with COD; therefore, both the mental and a substance use disorder must be present.
    - Every group member must contribute to the creation of the case study.

3. Be prepared to teach the larger group key information about your assigned disorder by describing the case study to us.

4. Be prepared to answer, "What did you learn that you can apply to your practice?"

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Module 8B

Introduction

A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues:
Mood & Anxiety Disorders, Schizophrenia & Other Psychotic Disorders

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Chapter's Format

- Disorder category (i.e. Personality, Mood, Anxiety, Psychotic)
  - What counselors should know about this category and substance abuse
- Specific disorders within each category
  - What counselors should know about substance abuse and the specific disorder
  - Diagnostic features and criteria from the DSM-IV-TR
  - Case study
  - Advice to the counselor

In This Module . . .

Module 8A

- Cross-Cutting Issues: Suicidality, Nicotine Dependence
- Personality Disorders

Module 8B

- Mood and Anxiety Disorders
- Schizophrenia and Other Psychotic Disorders

Module 8C

- Attention Deficit/Hyperactivity Disorder (AD/HD)
- Posttraumatic Stress Disorder (PTSD)
- Eating Disorders
- Pathological Gambling

Appendix D

TIP Exercise—Assignments

Group 1—Mood Disorder

- Diagnosis pp. 227–228
- Discussion pp. 226–230; and 369–383

Group 2—Anxiety Disorder

- Diagnosis p. 230
- Discussion pages *same as Mood Disorder*

Group 3—Schizophrenia

- Discussion pp. 231–235; and 385–400

TIP Exercise—Role Play

With your group:

- Review the text's sections on your assigned diagnosis and related information.
- Create a 3–5 minute role-play script that illustrates key information.
  - A scene likely to play out in your practice
  - All group members must have a role
- Teach us by performing your role play.

(20 minutes)

MODULE 8C: A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues: AD/HD, PTSD, Eating Disorders, Pathological Gambling

Objectives

- Chapter 8 in the TIP provides a brief overview for working with substance abuse treatment clients who also have specific mental disorders. The chapter's material has been divided into three (3) modules. Each module is intended to help participants become comfortable using the TIP as a reference for information on specific mental disorders from a COD perspective. The modules also help familiarize participants with Appendix D.
  - *Module 8A* addresses Suicidality, Nicotine Dependence and Personality Disorders.
  - *Module 8B* examines Mood and Anxiety Disorders, Schizophrenia and other Psychotic Disorders
  - ***Module 8C*** focuses on Attention Deficit/Hyperactivity Disorder (AD/HD), Posttraumatic Stress Disorder (PTSD), Eating Disorders, and Pathological Gambling.

Trainer Note:

- The following trainer notes are for Module 8C only.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 8C.1-8C.4
- Copies of the handout, one per participant *(See Handout section for master copy.)*
- Kitchen timer
- Markers and Post-It notes for participants to use on their TIP texts

Module Design

- The Module 8 cluster is designed to enable participants to explore and become comfortable with the TIP document, to appreciate the user-friendly format of Chapter 8, as well as to stimulate thought regarding application of the information to practice. Module 8C is primarily a small group activity during which participants review assigned text information in preparation for a brief panel presentation. A handout guides participants through the activity. The focus of the activity, however, is not the resulting panel presentation which given the time constraints cannot be in-depth. Rather the exploration of the text during the small group work and the sharing of the information with peers is the primary objective.

Seating

- At least four (4) small groups of 3-5 participants are needed. If the number of participants is small, dyads may be used instead. Should the trainer prefer participants to form groups with someone other than the persons they are likely to sit with initially, this re-seating should be carried out quickly before the module begins, perhaps as part of an ice-breaker or warm-up activity. However, time has not been allotted for this.

Time Management

- The bulk of the time allotted is to be spent on group work and reporting out. Use of a kitchen timer can help keep both trainer and participants on schedule so that all groups will have an opportunity to participate.

Suggested Timetable for Module 8C

Introduction ■ In This Module	3 minutes
TIP Exercise—Panel Presentation ■ Set up—*2 minutes* ■ Small Group Discussion—*18 minutes* ■ Report Out—*20 minutes*	40 minutes
Wrap up	2 minutes
TOTAL	**45 minutes**

2 minutes

OH #8C-1

Introduction

Reconvening

Trainer Note:

- Briefly review Module 8B by asking, *"During our last session, what did you learn that you could apply to your practice?"* and by soliciting a couple of participant responses. This is followed by a brief introduction to Module 8C.
- Check that everyone has a copy of the TIP. Lend copies or have people share.

In This Module . . .

OH #8C-2

- This is our last of three (3) sessions focused on Chapter 8 of the TIP text. Chapter 8 provides a brief overview for working with substance abuse treatment clients who also have specific mental disorders.
  - Module 8A addressed two (2) cross-cutting issues—suicidality and nicotine dependency, and it introduced personality disorders (PD) with attention to the borderline personality disorder and antisocial personality disorder.
  - In our previous session, Module 8B continued this overview and focused on mood disorders, anxiety disorders, schizophrenia and other psychotic disorders.
- ***ASK***—During our last session, what did you learn that you could apply to your practice? *(Solicit responses from a few participants.)*
  - **In Module 8C**, we will examine attention deficit/hyperactivity disorder (AD/HD), posttraumatic stress disorder (PTSD), eating disorders, and pathological gambling.

40 minutes

TIP Exercise—Panel Presentation

Trainer Note:

- The purpose of this activity is to familiarize participants with the information available in their TIP text on specific mental disorders, and to generate discussion regarding application of the information in a creative and relaxed manner.
- The trainer will need to be familiar with the activity's process and directions in order to clearly and quickly set-up the activity. The bulk of the time allotted is to be spent on group work and reporting out.
- ***Options for more than 20-25 participants***—If the number of participant groups is more than four (4), assignments can be duplicated. During report out, the "panels" for the topic will be larger, consisting of three (3) members from each group with the same topic. All will share the five(5)-minute report time.
- ***Group work***—Participants will spend 18 minutes in small groups reading and preparing for the panel presentation. Remember, the activity's process, not the resulting panel presentation, is of greatest importance.

2 minutes

Set up

Trainer Note:

- Divide participants into at least four (4) groups of 3-6 participants. Dyads can be used if the number of participants is small.
- ***Group assignments***—The trainer will assign groups to one of the following topics and chapter pages:
  - Group 1: AD/HD, pp. 235-237; and Appendix D, pp. 402-408.
  - Group 2: PTSD, pp. 238-240; and Appendix D, pp. 408-416.
  - Group 3: Eating Disorders, pp. 240-246; and Appendix D, pp. 417-425.
  - Group 4: Pathological Gambling, pp. 246-248; and Appendix D, pp. 425-436.

OH #8C-3

- As in the previous modules, we will be examining the material in small groups.
- Each group will be responsible for one of the disorders we are discussing today:
  - Group 1: AD/HD, pp. 235-237; and Appendix D, pp. 402-408.
  - Group 2: PTSD, pp. 238-240; and Appendix D, pp. 408-416.
  - Group 3: Eating Disorders, pp. 240-246; and Appendix D, pp. 417-425.
  - Group 4: Pathological Gambling, pp. 246-248; and Appendix D, pp. 425-436.

- The first pages refer to information in Chapter 8 on your assigned disorder. The second set of pages refers to the information in Appendix D on your assigned disorder. This information is also on your handout.

Trainer Note:

- Distribute the handout for the panel presentation activity and describe the activity.
- Participants will spend 18 minutes in small groups reading and preparing for the panel presentation.
- Remember, the activity's process, not the resulting panel presentation, is of greatest importance.

OH #8C-4

- Your group has been asked by the local college to participate in a panel presentation to counseling students. The topic is *"How to Recognize and Work with Substance Abuse Clients Who Also Have _____ Disorder."* You will fill in the blank with your assigned mental disorder.
- Your group's presentation will need to last between 3-5 minutes and address:
  - Essential features that would help a counselor recognize the disorder.
  - Very brief information on prevalence, assessment, and engagement. This information is available in Appendix D of your text in the section on your assigned disorder.
  - Other practical and important information that, in your opinion, counselors should know about working with substance abuse clients who also have your assigned disorder.
- At least three (3) of your group members will present as the panel. However, all members need to participate in helping prepare for the presentation.
- During the panel presentation, we will assume all of your audience members have a copy of TIP 42. So, as you present, you will refer participants to the text so they can follow along with you as you point out key information. However, you are guiding them, not reading straight from the text.
- You have 18 minutes to prepare for this panel presentation. Are there any questions?

18 minutes

Small Group Discussion

Trainer Note:

- Set timer for 18 minutes.
- Set up chairs and table at front of room for "Panel."
- The trainer should walk around the room to answer questions and make sure all group members participate and stay on task.
- Give a five (5)-minute warning.
- Give a one (1)-minute warning. Call time.

20 minutes

Report Out

Trainer Note:

- Each of the topic panels will have five (5) minutes to present. Remind them to refer to the text, guiding their "student audience" through pertinent material. Keep to the time limits so all "panels" can present.

- Remember that each of you will have no more than 3-5 minutes for your presentation. If necessary, I will call time so every group has a chance to report. We will start with Group 1, then Group 2, Group 3, and Group 4. Please move quickly to and from the front of the room.

Trainer Note:

- Have "panelists" sit at front of room.
- Solicit a participant volunteer to discreetly signal panel when two (2) minutes and one (1) minute remain.
- Congratulate and applaud groups at the end of their report while the next group takes its place at the front of the room.
- If possible, conclude the activity by having each group share what they have learned that they can apply to practice. If there is not enough time for this, it can be done as part of the introduction to the next session.

Conclusion

- Now, to end our session, I would like each group to share briefly what they have learned from today's session that they can apply to their practice.

Trainer Note:

- Quickly go around and have groups share what they have learned that they will apply to their practice.

2 minutes

Wrap up

Trainer Note:

- Thank all groups for their work and sharing their insights.
- Encourage participants to review the *Advice to Counselors* text boxes.
- Ask participants if there are any questions regarding the material in this module. Refer them to appropriate section of the text or to other resources if necessary.
- Remind participants of date, location and time of next session and to bring their copy of TIP 42.

Module 8C
PANEL PRESENTATION ASSIGNMENT

Group 1	**AD/HD** pp. 235-237 – Appendix D, pp. 402-408	**Group 3**	**Eating Disorders** pp. 240-246 – Appendix D, pp. 417-425
Group 2	**PTSD** pp. 238-240 – Appendix D, pp. 408-416	**Group 4**	**Pathological Gambling** pp. 246-248 – Appendix D, pp. 425-436

Your group has been asked by the local college to participate in a panel presentation to counseling students. Your topic is *"How to Recognize and Work with Substance Abuse Clients who Also Have _____ Disorder."*

(Fill in the blank with your assigned mental disorder.)

1. Your presentation will need to last between 3-5 minutes and address:
    a. Essential features that would help a counselor recognize the disorder.
    b. Very brief information on prevalence, assessment, and engagement. *(See Appendix D in the section on your assigned disorder.)*
    c. Practical important information that, in your opinion, counselors should know about working with substance abuse clients who also have your assigned disorder.

2. During the panel presentation, you will refer participants to the text so they can follow along with you as you discuss (not read) key information. We will assume members of your audience all have copies of TIP 42. (These are very smart students!)
    a. At least three (3) of your group members will present as the panel. However, all need to participate in helping prepare for the presentation.

3. You have 18 minutes to prepare for your panel presentation.

4. Also, be prepared to answer, "What did you learn that you can apply to your practice?"

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Module 8C

Introduction

A Brief Overview of Specific Mental Disorders and Cross-Cutting Issues:

ADHD, PTSD, Eating Disorders, Pathological Gambling

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Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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In This Module . . .

Module 8A

- Cross-Cutting Issues: Suicidality, Nicotine Dependence
- Personality Disorders

Module 8B

- Mood and Anxiety Disorders
- Schizophrenia and Other Psychotic Disorders

Module 8C

- Attention Deficit/Hyperactivity Disorder (AD/HD)
- Posttraumatic Stress Disorder (PTSD)
- Eating Disorders
- Pathological Gambling

Appendix D

TIP Exercise—Assignments

Group 1—AD/HD (pp. 235–237)

– Appendix D, pp. 402–408

Group 2—PTSD (pp. 238–240)

– Appendix D, pp. 408–416

Group 3—Eating Disorders (pp. 240–246)

– Appendix D, pp. 417–425

Group 4—Pathological Gambling (pp. 246–248)

– Appendix D, pp. 425–436

TIP Exercise—
Panel Presentation

With your group:

- Review the text's sections on your assigned diagnosis and related information.
- Create a 3–5 minute panel presentation on:

  "How to Recognize and Work with Substance Abuse Clients Who Also Have _____ Disorder "

  – Features to look for
  – Prevalence, assessment, and engagement
  – Practical information on working with client

(18 minutes)

MODULE 9: Substance-Induced Disorders

Objectives

- Module 9 briefly reviews substance-induced disorders. The module is intended to help participants become comfortable using the TIP as a reference for information on the toxic effects of substances that can mimic mental illness. The module also briefly explains the format of Appendix F in the context of the preceding modules: Modules 8A, 8B and 8C.

Materials Needed

- Extra copies of TIP 42 should participants forget their copy
- Overhead projector or laptop computer and LCD projector for slides
- Slides # 9.1-9.5
- Copies of the handout, one per participant *(See Handout section for master copy.)*
- Slips with the substance assignment for each small group in the TIP Exercise
- Kitchen timer
- Markers and Post-It Notes for participants to use on their TIP texts

Module Design

- Module 9 examines substance-induced disorders through a guided review of the text material and an activity that allows participants, through small and large group discussions, to apply the information on the toxic effects of substances that can mimic mental illness in ways that can be difficult to distinguish from mental illness.

Familiarity with Content

- The trainer will need to be familiar with the text, including Appendix F, the script and handouts for the activity. Several decisions will need to be made in advance of the session.

Seating

- Small groups of 3-5 participants are needed. The number of groups will be determined by the number of "substances" assigned in the TIP Exercise (see TIP Exercise below). If the number of participants is small, dyads may be used instead of small groups. Should the trainer prefer participants to work in groups with someone other than the persons they are likely to sit with initially, this re-seating should be carried out quickly before the module begins, perhaps as part of an icebreaker or warm-up activity. However, no time has been allotted for this.

Time Management

- The pace of this module is brisk, so the trainer will need to be well prepared. During the small group discussions, the trainer should move about the groups, clarifying directions if necessary and making sure participants stay on task as only 15 minutes are reserved for development of the case. The report out/ peer teaching also must keep to the 15 minute time limit. If reports are kept to the recommended three (3) minutes per group, there will be enough time to accommodate five (5) groups. Fewer groups will allow for more reporting time.

Suggested Timetable for Module 9	
Introduction ■ Reconvening and Review of Chapter 8 ■ Review of Appendix F	5 minutes
In this Module ■ Substance-Induced Disorders	5 minutes
TIP Exercise—The Case of the Substance-Induced Disorder ■ Set up—*2 minutes* ■ Small Group Discussion—*15 minutes* ■ Large Group Activity—*15 minutes*	32 minutes
Wrap up	3 minutes
TOTAL	**45 minutes**

5 minutes

OH #9-1

Introduction

Reconvening and Review of Chapter 8

Trainer Note:

- The initial review of Modules 8A, 8B and 8C serves as segue to a brief examination of Appendix F with emphasis on familiarizing participants with the format and the overall content of the appendix. It is not the focus of the module and should be covered quickly.
- Check that everyone has a copy of the TIP. Lend copies or have people share.

OH #9-2

- In our last sessions, we examined Chapter 8. We examined two (2) cross-cutting issues: suicidality and nicotine dependence. Then we explored the text's material on several mental disorders, including personality disorders, mood and anxiety disorders, schizophrenia and other psychotic disorders, as well as AD/HD, PTSD, eating disorders and pathological gambling. These mental disorders were discussed from the perspective of their occurring with a substance use disorder. Wherever possible, the interaction of the mental and substance use disorders was illustrated to provide insight into the complexity of diagnosing and treating clients with COD.
- We also explored Appendix D, which is a companion to Chapter 8, providing information on the disorders discussed, but in more detail.

Review of Appendix F

- One final topic related to this discussion is medication. Treatment for many of the disorders we discussed in Chapter 8 often includes medication. Appendix F is a resource in this area. Please turn to page 459, or Appendix F, in your text. *(Allow participants to access page 459.)*
- The initial pages provide a succinct and clear introduction to pharmacologic risk factors and how these influence treatment approaches. Because medications often produce both therapeutic and detrimental effects, prescribing medication involves striking a balance between these.

- On page 460, in the middle of the left column, the text explains that with regard to clients with co-occurring disorders, special attention should be given to detrimental effects, in terms of:
  - Medication compliance
  - Abuse and addiction potential
  - Substance use disorder relapse
  - Psychiatric disorder relapse
- Starting on page 463, the appendix contains an adaptation of a handbook published by the Mid-America Addiction Technology Transfer Center titled *Psychotherapeutic Medications 2004: What Every Counselor Should Know. (Allow participants to access page 463.)*
- After some tips for effectively communicating with physicians and with clients about medications, information on several classes of drugs is presented in a way that is useful to practitioners. For example, please turn to page 465. *(Allow participants to access page 465.)*
- Examination of antipsychotic/neuroleptic drugs begins on this page. The material for each broad category of medication is presented in a consistent format:

Trainer Note:

- Pause briefly after each of the following to allow participants to glance at the material.

  - First is a list of the most common generic names, and the corresponding brand names
  - Next, is the purpose for this medication in treatment
  - Usual dose information
  - Potential side effects
  - Emergency conditions
  - Cautions
  - Special considerations for pregnant women

- If you look on page 468, discussion of antimanic medication begins here. *(Allow participants to access page 468.)*
- Again, the information is presented in the same format, making it easy for practitioners to find needed information:
  - First is a list of the most common generic names, and the corresponding brand names
  - Next, the purpose for this medication in treatment
  - Usual dose information
  - Potential side effects
  - Emergency conditions
  - Cautions
  - Special considerations for pregnant women

OH #9-3

- Appendix F includes information in this same format for various types of medications including:
  - Antipsychotics
  - Antimanic medications
  - Antidepressants
  - Antianxiety medications
  - Stimulants
  - Narcotics
  - Antiparkinsonian medications
  - Hypnotics
  - Addiction treatment medications

- For those interested in the more current version of this handbook, *Psychotherapeutic Medications 2006: What Every Counselor Should Know*, it is available for free download at www.mattc.org.

Trainer Note:

- Transition to Chapter 9.

- Chapter 9, the main topic of today's session, also involves drugs and mental disorders. Instead of talking about the use of drugs to alleviate the symptoms of mental disorder, Chapter 9 discusses instances when drugs *cause* symptoms of mental disorder.

5 minutes

OH #9-4

In this Module . . .

Substance-Induced Disorders

- Chapter 9 in the TIP text focuses on symptoms of mental illness that are the result of substance abuse. This is a condition referred to as "substance-induced mental disorders." We will examine some of the substances more commonly associated with these disorders.
- Substance-induced disorders are distinct from independent co-occurring mental disorders in that all or most of the psychiatric symptoms are the direct result of substance use.
- On page 249 is a list of various substance-induced disorders defined in the DSM-IV-TR *(Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision)* (American Psychiatric Association [APA] 2000). Please turn to page 249. *(Allow participants to access page 249.)*
- This list reflects the many ways that the toxic effects of substances can mimic mental illness. Often this presents in ways that can be difficult to distinguish from a true mental disorder. Substance-induced disorders include:
  - Substance-induced delirium
  - Substance-induced persisting dementia
  - Substance-induced persisting amnestic disorder
  - Substance-induced psychotic disorder
  - Substance-induced mood disorder
  - Substance-induced anxiety disorder
  - Hallucinogen persisting perceptual disorder
  - Substance-induced sexual dysfunction
  - Substance-induced sleep disorder
- The text box on page 253 provides an example of the diagnostic criteria for one (1) of these diagnoses, that of substance-induced mood disorders. *(Allow participants to access page 253.)*

- The criteria include:

  1. A prominent and persistent disturbance in mood predominates, characterized by

     (a) a depressed mood or markedly diminished interest or pleasure in activities, or

     (b) an elevated, expansive, or irritable mood.

  2. There is evidence from the history, physical examination, or laboratory findings that the symptoms developed during or within a month after substance intoxication or withdrawal, or medication use, is etiologically related to the mood disturbance.

  3. The disturbance is not better explained by a mood disorder.

  4. The disturbance did not occur exclusively during a delirium.

  5. The symptoms cause clinically significant distress or impairment.

- It is important to keep in mind that a substance-induced disorder does not rule out the presence of a co-occurring mental disorder. Instead, it indicates that the specific symptom cluster at a specific point in time is more likely the result of substance use, abuse, intoxication, or withdrawal rather than of underlying mental illness.

- At the bottom of page 249, the text provides an example of how a client might have both independent and substance-induced mental disorders. For example, a client may present with well-established independent and controlled bipolar disorder and alcohol dependence in remission, but the same client could be experiencing amphetamine-induced auditory hallucinations and paranoia from an amphetamine abuse relapse over the last three (3) weeks. *(Allow participants to access page 249.)*

- On page 250, the text discusses the wide range of symptoms of substance-induced disorders. These run the gamut from the most common, that of mild anxiety and depression to the less common full-blown manic and other psychotic reactions. *(Allow participants to access page 250.)*
  - When trying to predict what kind of syndrome or symptoms might be caused by what substances, the text suggests that the "teeter-totter principle" (i.e., "what goes up must come down") can be useful.
    - For example, acute withdrawal symptoms from physiological depressants such as alcohol and benzodiazepines are hyperactivity, elevated blood pressure, agitation, and anxiety (i.e., the shakes).
    - On the other hand, those who "crash" from stimulants are tired, withdrawn, and depressed.
  - Virtually any substance taken in very large quantities over a long enough period can lead to a psychotic state.
- However, the text stresses that prediction of any particular substance-related syndrome is limited because clients vary greatly in how they respond to both intoxication and withdrawal given the same exposure to the same substance, and because different substances may be taken at the same time.
- Instead, the text highlights how important it is to continue to evaluate psychiatric symptoms and their relationship to abstinence or ongoing substance abuse over time.
  - Most substance-induced symptoms begin to improve within hours or days after substance use has stopped.
  - Exceptions to this are psychotic symptoms caused by heavy and long-term amphetamine abuse and the dementia (problems with memory, concentration, and problem solving) caused by using substances directly toxic to the brain, which most commonly include alcohol, inhalants like gasoline, and again amphetamines.
- On page 252, the text addresses some important diagnostic considerations that we will briefly review now. However, you are encouraged to read this section carefully at your convenience. *(Allow participants to access page 252.)*
- Diagnoses of substance-induced mental disorders will typically be provisional and will require reevaluation-sometimes repeatedly.
- Many apparent acute mental disorders may really be substance-induced disorders.
- On the other hand, people who have what appear to be substance-induced disorders may turn out to have both a substance-induced disorder *and* an independent mental disorder.

- For most people who are addicted, drugs eventually become more important than jobs, friends, family, and even children. These changes in priorities can look, sound, and feel like a personality disorder. The true diagnostic picture, however, might not reveal itself for weeks or months.
- Treatment of the substance use disorder and an abstinent period of weeks or months may be required for a definitive diagnosis of an independent, co-occurring mental disorder.
- Substance abuse treatment programs and clinical staff can concentrate on screening for mental disorders and determining the severity and acuity of symptoms, along with an understanding of the client's support network and overall life situation.
- On pages 250, 251 and 252, the text provides an overview of the most common classes of substances of abuse and the accompanying psychiatric symptoms seen in intoxication, withdrawal, or chronic use.

Trainer Note:

- Transition to TIP Exercise.

- During the remainder of our session, you will bring these descriptions to life through a group exercise.

32 minutes

OH #9-5

TIP Exercise—The Case of the Substance-Induced Disorder

Trainer Note:

- The purpose of this activity is to familiarize participants with the information available in their TIP text on substance-induced disorders, to synthesize material presented in the previous chapters, and to provide an enjoyable and relaxed opportunity for peer teaching.
- The trainer will need to be familiar with the script and handouts in order to set up the activity with a minimum of participant questions. The bulk of time allotted is to be spent on small and large group activities.
- Fifteen (15) minutes have been assigned for the case development and 15 for the "report out" to the larger group—or three (3) minutes per group for five (5) groups. The trainer will need to keep participants on task and on time, keeping in mind, however, that the point of the activity is NOT a perfect case study for but for all participants to examine and apply the text, and enjoy the learning process.

2 minutes

Set Up

Trainer Note:

- Divide participants into groups of 3-5 participants. The number of small groups will be determined by the number of substances chosen for assignment. Dyads can be used instead if the number of participants is small. For larger groups, duplicate assignments can be made, but not all groups will be able to report out.
- Each small group will focus on one (1) substance from pages 250-252. The trainer will need to decide beforehand which substances to assign based on the learning needs of the participants.
- ***Instructions and Substance Slips:*** Participants will each need a copy of the master handout *The Case of the Substance-Induced Disorder* (see handout section) which provides instructions for the activity. It will be used by the trainer when explaining the activity to participants. Also provided in the handout section is a master copy for the substance assignment slips.
- ***Substance Assignment:*** Hand out a folded slip with the assigned substance, one (1) per group, or let a member of the group pick a slip from a container. The substance selected should be kept "secret" from the other groups.

- In your small groups, you will be creating a case study involving a substance-induced disorder.
- I have handed out a slip with your assigned substance. The other groups will have to guess what it is, based on your case information, so please keep your assigned substance a secret.
- Now let's review your handout.
- First, you will read the section in your text on the substance selected by your group.
- Then, with your group, create a brief case study of an imagined "client" who receives services at your agency.
  - Your "client" must have a history of a substance use disorder and a mental disorder. The client may be showing symptoms of the mental disorder and substance use disorder, or not. The choice is yours.

  - The client is currently experiencing symptoms of a substance-induced disorder caused by either use or withdrawal from the substance you selected. This may be the same as or different from the substance of the diagnosed substance use disorder. However, the staff at your agency is not aware of the client's current use.
  - Write a brief history and description of the current situation and the client's observable symptoms and behavior—no more than two (2) or three (3) paragraphs long. In addition to symptoms of the substance-induced disorder, this description may include symptoms related to the mental disorder and substance use disorder (or not, depending on your previous decision). You can make it easy or hard for us to guess.

- Your group will read this description to the larger group who now make up part of the "treatment team."
- Each small group will be able to ask your group one (1) question about the case (except for the answer). The group will then try to guess the substance causing the symptoms of the substance-induced disorder and give their reasons.
- If a group guesses correctly it will win our everlasting admiration and applause!
- After all groups have guessed once or the correct answer is guessed, your group will debrief the larger group regarding the four (4) key points of what you read about your selected substance. Use any applicable details of your "case" as illustrations.
- You will have 15 minutes to develop your case, and three (3) minutes to "present." I am sure we will have some interesting cases!

15 minutes

Small Group Discussion

Trainer Note:

- Set timer for 15 minutes.
- Walk around the room to answer questions and ensure participants are on task.
- Remember, the intent of the exercise is NOT a perfect case study but for all participants to access and apply the text.
- Give a two (2)-minute warning. Call time.

15 minutes

Large Group Activity

Trainer Note:

- Have a group present their case.
- Allow each of the other groups to ask one (1) question and guess the substance.
- When all have tried to guess once, have the presenting group share the four (4) key points from their reading on the assigned substance.
- Keep the pace brisk but enjoyable.
- Ensure that all groups have a chance to report.

- Each group will have a turn to present their case. We will start with _____.
- The rest of the small groups will try to guess the substance causing the symptoms of the substance-induced disorder and give their reasons. Each group will be allowed to ask one (1) question about the case (except for the answer) before guessing.
- After all the groups have guessed once or the correct answer is given, your group will teach us four (4) key points about your selected substance. Use details of your "case" if they apply to illustrate.
- Let's begin.

Trainer Note:

- Monitor the time to ensure that all groups have a chance to report.

3 minutes

Wrap up

Trainer Note:

- The facilitator wraps up this last session by thanking the participants and briefly repeating the overarching goal of all the sessions, which were designed for practitioners to:
  - Become familiar with the TIP 42 document
  - Explore the variety of information available in the TIP
  - Discuss key concepts
  - Apply the information to clinical situations

- This is the final module in our exploration of TIP 42. The primary goal of our sessions has been to familiarize you with the structure and content of the TIP by having you explore it, write in it, discuss it, apply it to clinical situations, and make it your own. Ultimately, the intent was to motivate you to take advantage of this valuable resource in your everyday practice.
- A secondary goal, however, was that these sessions would be enjoyable opportunities for us to learn from each other. Thanks to your hard work and collaborative spirit, I believe we have succeeded.

Module 9
THE CASE OF THE SUBSTANCE-INDUCED DISORDER

- Read the section in your text on the substance selected by your group.
- With your group, create a brief case study of an imagined "client" who receives services at your agency.
  - Your "client" must have a history of a substance use disorder and a mental disorder. The client may be showing symptoms of the mental disorder and substance use disorder, or not. The choice is yours.
  - The client is currently experiencing symptoms of a substance-induced disorder caused by either use or withdrawal from the substance you selected. This may be the same as or different from the substance of the diagnosed substance use disorder. However, the staff at your agency is not aware of the client's current use.
  - Write a brief history and description-no more than two (2) or three (3) paragraphs long—of the current situation and the client's observable symptoms and behavior. In addition to symptoms of the substance-induced disorder, this description may include symptoms related to the mental disorder and substance use disorder (or not, depending on your previous decision).
- Your group will read this description to the larger group who now make up part of the treatment team.
- Each small group will be able to ask your group one (1) question about the case (except for the answer). They will then try to guess the substance causing the symptoms of the substance-induced disorder and give their reasons.
- If a group guesses correctly it will win our everlasting admiration and applause.
- After all the groups have guessed once or the correct answer is given, your group will teach the rest of us four (4) key points about your selected substance. Use details of your "case" to illustrate if they apply.

Module 9
SUBSTANCE SLIPS FOR THE TIP EXERCISE

- Choose the substances most appropriate to participant needs and interests.
- Cut enough slips so each small group will have one (1) assigned substance.
- Fold so they are not visible to other groups.
- Provide a container if slips are to be “picked” by a small group member.

Alcohol	Alcohol
Caffeine	Caffeine
Cocaine	Cocaine
Hallucinogens	Hallucinogens
Nicotine	Nicotine
Opioids	Opioids
Sedatives	Sedatives

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U.S. Department of Health and Human Services

Module 9

Introduction

Substance-Induced Disorders

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Chapter 8

Module 8A

- Cross-Cutting Issues: Suicidality, Nicotine Dependence
- Personality Disorders

Module 8B

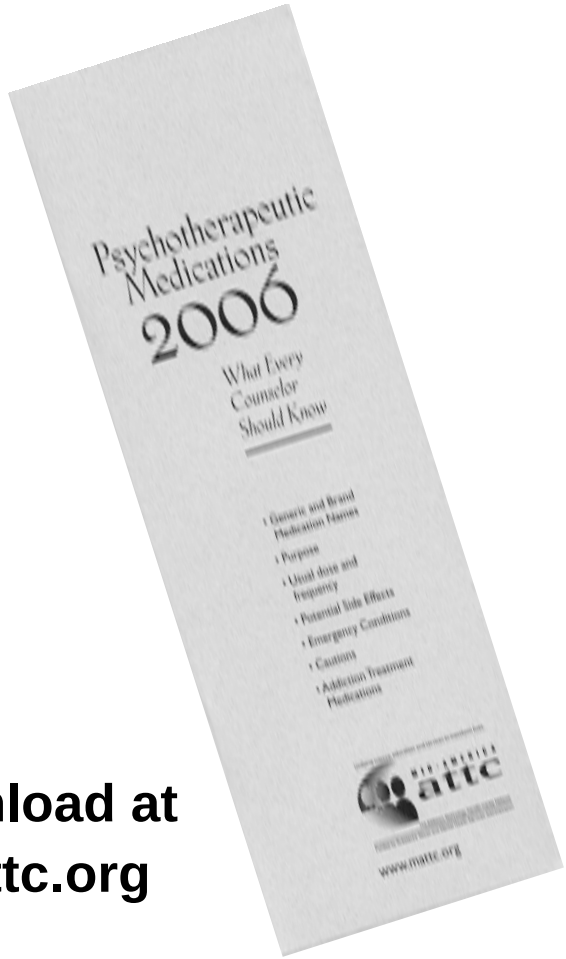
- Mood and Anxiety Disorders
- Schizophrenia and Other Psychotic Disorders

Module 8C

- Attention Deficit/Hyperactivity Disorder (AD/HD)
- Posttraumatic Stress Disorder (PTSD)
- Eating Disorders
- Pathological Gambling

Appendix D

What Every Counselor Should Know



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Types of medications:

- Antipsychotics
- Antimanic
- Antidepressants
- Antianxiety
- Stimulants
- Narcotics
- Antiparkinsonian
- Hypnotics
- Addiction treatment

In This Module . . .

- Substance-Induced Disorders
  - Description
    - Alcohol
    - Caffeine
    - Cocaine and Amphetamines
    - Hallucinogens
    - Nicotine
    - Opioids
    - Sedatives
  - Diagnostic Considerations
  - Case Studies
  - Appendix F

TIP Exercise—
Substance-Induced Disorders

With your group:

- Review the text's sections on the assigned substance.
- Use your handout to create a brief case study.

(15 minutes)

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